EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE REGARDING ANOREXIA NERVOSA AMONG ADOLESCENT GIRLS IN A SELECTED COLLEGE AT SIVAGANGAI

REG. NO: 301331551

A DISSERTATION SUBMITTED TO THETAMILNADUDR.M.G.R. MEDICALUNIVERSITY, CHENNAI, IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

OCTOBER 2015

CERTIFICATE

This is to certified that the dissertation entitled "**EFFECTIVENESS OFSTRUCTURED TEACHING PROGRAMME ON KNOWLEDGE REGARDING ANOREXIA NERVOSA AMONG ADOLESCENT GIRLS IN SELECTED COLLEGE AT SIVAGANGAI"** is submitted to the faculty of Nursing, **The Tamilnadu Dr. M.G.R Medical University,Chennai by Mrs. I.Flarence Anitha** in partial fulfillment of the requirement for the degree of Master of Science in Nursing. It is the bonafide work done by her and the conclusions are her own. It is further certified that this dissertation or any part thereof has not formed the basis for award of any degree, diploma or any title.

Dr.Prof.S.Rajina Rani M.Sc(N),Ph.D,
Principal,
RASS Academy College of Nursing,
Poovanthi,Sivagangai Dist-630611.
Tamilnadu.

EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE REGARDING ANOREXIA NERVOSA AMONG ADOLESCENT GIRLS IN A SELECTED COLLEGE AT SIVAGANGAI

APPROVED BY THE DISSERTATION COMMITTEE ON SEPTEMBER 2014

RESEARCH GUIDE **: ----------**

Dr.Prof.S.Rajina Rani, M .Sc (N), PhD.
Principal,
RASS Academy College of Nursing
Poovanthi, SivagangaiDist – 630611.

CLINICAL GUIDE **: ----------**

Prof.Mrs. R. Ruth Rani, M.Sc. (N),
Professor,
HOD of Psychiatric Nursing,
RASS Academy College of Nursing,
Poovanthi, Sivagangai Dist.

MEDICAL GUIDE **: ----------**

Dr.V.Ramanujam, MBBS, MD, (PSY)
Medical officer,
Srinivasa Hospital,
Madurai.

A DISSERTATION SUBMITTED TO THE TAMILNADU DR.M.G.R. MEDICAL UNIVERSITY, CHENNAI IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF

MASTER OF SCIENCE IN NURSING

OCTOBER 2015

ACKNOWLEDGEMENT

I, the investigator to thank, praise and glorify the Almighty God, with all my heart, for his constant love, blessings, guidance to make this study in a Successful part of my requirement.

I would like to extend my sincere thanks to **Mr.C.Ravisankar,Chairman,** RASS Academy college of Nursing, Poovanthi for his support and for providing the required facilities for the successful completion of this study.

I express my heartfelt and sincere thanks to my research guide **Dr.Prof.S.RajinaRani,MSc(N),Ph.D,RASS Academy college of Nursing,Poovanthi** for a deniable work,interest,cheerful approach,always with never ending willingness to provide expert guidance and suggestion to mould this study to the present form.

I extend my warmest thanks to **Associate Prof.H.Ummul Hapipa, M.Sc (N)., Vice-Principal, RASS Academy college of Nursing, Poovanthi** for her expert guidance, valuable suggestion to bring this study in successful way

My heartfelt and sincere thanks to my medical guide My deep sense of gratitude to **Dr.V. Ramanujam,M.B.B.S, M.D.,(PSY)**for his help, valuable guidance and encouragement which enabled me to accomplish this task.

My words are inadequate to thank my clinical specialty guide Associate **Prof.Mrs.R. Ruth Rani, M.sc (N), Head of the department of Mental Health Nursing, RASS AcademyCollege of Nursing, Poovanthi** for motivation, advice, feedback and encouragement.

My deep sense of gratitude to **Asso.Prof.M.Uma Maheshwari,M.Sc(N),HOD of Community Health Nursing Dept, RASS Academy College Of Nursing, Poovanthi,** for her support and valuable suggestions to bring this study in a success.

I express my warmest thanks to,**Associate Prof.J.Vijayalakshmi M.sc (N) Child health nursing,**for her support and valuable suggestions to bring this study in a success.

I extend my sincere thanks **to Mrs.K.Sangeetha, M.Sc(N),Reader,Department Of Mental Health Nursing**,RASS Academy College of Nursing, Poovanthi for her support and valuable suggestions to bring this study in a success.

I extend my sincere thanks to **Mrs.P.S.Saranya, MSc(N),Reader, Department of Obsteristics & Gynaecological Nursing,** RASS Academy College of Nursing for their cheerful approach, as their hands out stretched always with never ending willingness to provide guidance and suggestions.

I extend my sincere thanks to.**Mrs.Paramewari,MSc(N),Lecturer,**Obstetrics and Gynaecology, **Mrs.Kartheeswari,MSc(N),Lecturer,** Medical Surgical Nursing Dept**, Mrs.Kavitha, M.Sc (N),Lecturer,** Medical Surgical Nursing Dept**, Ms.P.Kosalai Ramani M.Sc (N), Lecturer,** Child Health Nursing Dept**, Mrs.G.Selvi, B.Sc(N), Ms.J.Kanimozhi, B.Sc(N),**RASS Academy College of Nursing, Poovanthi for them help, valuable to complete this study in a successful way.

I express my sincere thanks to **Mr.T.S.Devadass**, Administrative Officier,**Mrs.M.Muthulakshmi**, Administrative Assistant, Mrs.**S.Jothimani**,Librarian, RASS Academy College Of Nursing for them support to bring this study in a success.

My Sincere thanks to **Dr.Varadharajan,M.Sc.,M.Phil.,M.Ed.,Ph.D(Edn), Professorof Psychology,** RASS Academy College of Nursing, Poovanthi for his help in the statistical analysis of the data which is core of the study.

I extended my special thanks to **adolescent girls** who participated in this study, without them this should not have been a success

I immensely thankful to my beloved husband **Mr.A.Stephen Michael** for his support and co-operation, and his help to make this study as a success one.

I extended my special thanks to **adolescent girls** who participated in this study, without them this should not have been a success.

I express my sincere thanks to **powe**r **Xerox** Sivagangai, for their artistic and

innovative work to bring out the study into a printed form.

I express my sincere thanks to my lovable Parents **Late**.**Mr.A.Irudhyasamy, Mrs.A.Jebamalai** for their prayer, economical support and encouragement in my research.

I express my sincere thanks to my lovable in laws **Mr.S. Antony, Mrs.A. Michael Mary** for them support and encouragement in my research.

I express my sincere thanks to my beloved Brother **Mr.I.Rajesh Antony** and **Mrs. Rakhi Rajesh,**my dear sister **Mrs.I.Anjeline** for their blessings, support and encouragement in my research.

Finally I would like to acknowledge the efforts of **my seniors Mrs.Tamilselvi, Ms.Mahalakshmi and my classmates Mrs.Rosamma Ms.Kavitha, Ms.Mesiya, Mrs.Devika, Mrs.Jayalakshmi,** for their encouragement and support all through my ups and downs during my study.

I dedicate this study to my beloved husband Mr .A. Stephen Michael and my lovable kids S.Joel Antony, S.Joanna and my family .

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

ABSTRACT

The study on **"EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE REGARDING ANOREXIA NERVOSA AMONG ADOLESCENT GIRLS IN SELECTED COLLEGE AT SIVAGANGAI**" was undertaken by **Reg.No: 301331551** during the year 2013-2015 in partial fulfillment of the requirement for the degree of Master of Science in Nursing at RASS Academy College of Nursing, Poovanthi which is affiliated to the Tamilnadu, Dr.M.G.R. Medical University, Chennai.

Objectives: To assess the pretest knowledge regarding anorexia nervosa among adolescent girls. To evaluate the effectiveness of structured teaching programme on knowledge regarding anorexia nervosa among adolescent girls. To find out the association between the pretest knowledge regarding anorexia nervosa with their selected demographic variables.**Conceptual frame work:** It was based on General System Theory and **Design** Pre-experimental one group pre test &post test design was adopted for this study. **Setting:** The study was conducted in Madurai Sivakasi Nadar's Meenakshi Pioneer Women's College at Sivagangai district. **Sample size:** The sample size was 100 adolescent girls.**Sampling technique:** The purposive sampling technique was used. **Method of data collection procedure:** Data were collected from the adolescent girls to assess the level of knowledge among the adolescent girls by using structured questionnaire before and after structured teaching programme.The collected data were tabulated and analyzed by descriptive and inferential statistics. **Results:** Structured teaching programme is effective of adolescent girls according to level of knowledge before and after the manipulation in which (80%) of the samples had showed inadequate level of knowledge in the pre-test. In contrast 96% of the samples experience adequate level of knowledge in the post test. The mean post-test knowledge score(26.03) was greater than the mean pre-test level of knowledge score 12.22%. The obtained t- value (44.54) was greater than table value at 0.05 level of significance. It shows the structured teaching programme was effective in improving knowledge. **Conclusion:** This study shown that Structured Teaching Programme had a significant effect in improving knowledge of adolescent girls.

CHAPTER – I

INTRODUCTION

CHAPTER-1

INTRODUCTION

The human body uses food and water as fuel to sustain itself during adolescence there are many taking place as a child's body turns into that of an adult and their nutritional needs increase.

Gale CJ (2013), Due to paucity of literature regarding parent attitudes towards adolescent problems, the subject is covered only in limited fashion. Following this is a discussion of adolescent attitudes forward problem of eating habits. There is a growing concern that teens need to be aware of interventions available to them. More research is needed to survey adolescent attitudes toward the various high risk behaviours, as well as determine how to promote help seeking behaviours and positive youth development.

Institute of Medicine (US) and National Research Council (2011) Adolescents are subjected to a barrage of messages and pressures affecting how they view themselves and how they believe they should look. It is a period when peer pressure can affect teenage eating behaviour and they may start skipping meals to maintain body size and shape.

In many cultural and historical periods women have proud to be large, being fat was a sign of fertility, of prosperity, of the ability to survive. And there was less concerned dieting, fatness, weight fluctuation is among women. Women being fat often face hostility and discrimination.

Dannis (1996)"Adolescent refers to the period "from puberty to maturity". During which physical, emotional and psychological changes occur in them. Young people are the future of every society and also a great resource for the nation. During the transition from childhood to adulthood, adolescents, establish patterns of behaviour and make lifestyle choice that affect both their current and future health adolescents and young adults are adversely affected by serious health and safety issues such as slim beauty maintenance and violence and sexual behaviour etc.

Environmental factors such as family, peer group school, and community characteristics also contribute to the challenges that adolescents face.

Food is the prime necessity of life. The food we eat is digested and assimilated in the body and used for its maintenance and growth, during adolescence, physiological age is a better guide to nutritional needs than chronological age. Energy needs to increases to meet greater metabolic demands of growth; healthy diet is the diet that is arrived with the intent of improving or maintaining optimal health. The diet includes all the nutrients in appropriate amounts from all food groups including an adequate amount of water.

Normal weight and underweight teenage girls who falsely believe they are overweight are at greater risk of succumbing to unnecessary and unsafe weight loss behaviour than girls, who can accurately assess their weight status according to research by university of Illinois expect in eating disorder and body image perception. Body image distortion appears to be more discriminating indicators of distress than body dissatisfaction but it's not something that's typing screen by health care providers.

Adolescence is a period of psychosocial changes that is often perplexing for both teens and their parents. The rapid physical changes that occur at this time lead adolescents to become preoccupied with their body image.

The term anorexia nervosa was established in 1873 by sir. William gull, one of the queen Victoria personal physicians, the term is of Greekorigin, "a prefix denoting negation and orexis" prefix denoting appetite. This means a lace of desire to eat people with anorexia have an extreme fear of weight gain and a distorted view of their body size and shape. As a result, they strive to maintain a very low body weight; some restrict their food intake by dieting, fasting or excessive. They hardly eat all and often try to eat as few calories as possible, frequently obsessing over food intake.

Anorexia nervosa is an eating disorder characterized by a fierce quest for thinness. The DSM-IV and ICD-10, defines patients with anorexia nervosa as having an intense fear of gaining weight, putting undue influence on body shape or weight for self-image, having a body weight which is less than 85% of the weight that would be predicted, and missing at least three consecutive menstrual periods.

Anorexia is an emotional disorder that focused on food. But it is actually an attempt to deal with perfectionism and a desire to control things by strictly regulating

food and weight people with anorexia often feel that their self-esteem is tied to how this they are anorexia is increasingly common especially among young women in industrialized countries where cultural expectations encourage women to be thin, fuelled by popular fixations with thin and lean bodies.

Laura k. (2013) Anorexia nervosa is an eating disorder. It occurs when a person's obsession with dieting and exercise leads to excessive weight loss. People are generally considered anorexia when they refuse to maintain their body weight at or above 85% of their ideal body weight anorexia can be fatal.

Toby D,(2013) It is often coupled with distorted self-image which may be maintained by various cognitive biases that after how the affected individual evaluates and thinness about her or his body, food and eating persons with anorexia nervosa continue to feel hunger, but denial themselves to have small quantities of food, the average calorie intake of person with anorexia nervosa is 600-800 calories per day, but extreme cases of complete self-starvation are know the is a serious mental illness with a high incidence of co morbidity.

G. Stanley (2011) Adolescents may become preoccupied with themselves, uncertain about their appearance, compare their bodies with those of other teens, and become increasingly interested in sexual anatomy and physiology, anorexia nervosa is an eating disorder that disproportionately affects adolescents and has its origin, at least partially, in this preoccupation with body image.

Anorexia often leads to a number of serious medical problems including; amenorrhea, osteoporosis, cardiac abnormities.

The cause of anorexia nervosa is not known. It appears that hereditary due to genetics, family and learned behaviour, culture and media and restrictive eating severe trauma or emotional stress during puberty or pre puberty. Abnormalities in brain chemistry.A tendency towards perfectionism fear of being humiliated and family history of anorexia. Approximately 95 percentages of those affected by anorexia are female, but males can develop the disorder as well. It begins to manifest itself during later adolescence; it is also seen in young children and adults.

Fairburn (1999) The risk factor of anorexia nervosa are age, gender, dieting, weight gain, weight loss, low self-esteem, feelings of helplessness, perfectionism, fear

of becoming overweight, familial pressure to be thin families that are overprotective, rigid under involved, or in conflict, family history of eating disorders, emotional stress, mood disorders such as depression or generalized anxiety disorder, personality disorders, susceptibility to social and fashion trends emphasizing or glamorizing thinness, history of sexual abuse or other traumatic event , experiencing a big life change, such as moving or going to a new school.

Pryor T. The diagnosis of anorexia is lab tests may include blood tests- to look for signs of anaemia to check electrolytes, and to check liver and kidney function, electro cardiogram to look for abnormal heart rhythms, bone density test –to check for osteoporosis, scoff questionnaire developed in Great Britain.

A "yes" response to at least 2 of the following questions is a strong indicator of an eating disorder.

S: "do you feel sick because you feel full?"

C: "do you lose control over how much you eat?"

O: "have you lost more than 13 pounds recently?"

F: "do you believe that you are fat when others say that you are thin?"

F: "does food and thoughts of food dominate your life?"

The signs and symptoms of anorexia is severe weight loss. Physical signs including excusive weight loss, scanty or absent menstrual periods, thinning hair, dry skin, brittle hails, cord or swollen hands and feet bloated or upset stomach downy hair covering the body ,low blood pressure fatigue, abnormal heart rhythms, osteoporosis, psychological and behaviour sighs including distorted self-perception, being preoccupied with food, refusing to eat, inability to remember things, refusing to acknowledge the seriousness of the illness, obsessive compulsive behaviour, depression.

The most effective way to prevent anorexia is to develop healthy eating habits and a strong body image from an early age. Don't accept cultural values that place a premium on thin, perfect bodies. Family and friends should be urged not to focus on the person's condition, or on food or weight.

The most successful treatment is a combination of psychotherapy, family therapy, and medication. It is important for the person with anorexia to be actively involved in their treatment. Combination of treatments can give the person the medical psychological, and practical support they need cognitive behavioural therapy, along with anti-depressants can be an effective treatment for eating disorders.

NEED FOR THE STUDY

Adolescence is a period separate from both early childhood and adulthood. It is a transitional period. That requires special attention and protection. Evidence shows that when adolescence girls and boys are supported and encourage by caring adults, along with policies and services attentive to their needs and capabilities, they have the potential to break long standing clueless of potential, discrimination and violence.

According to WHO adolescence is the age of 13-21 years and it comprises about one-fifth of the world's population, which is equivalent to 1.2 billion young person (UNFPA, 2003) the WHO declares the adolescence are the adults of tomorrow and to ignore their needs is difficult unwise and unjust. It is also called as period of stress and storm, a period when society sends mixed signals to its youngsters which results in confusion, frustration, despair and risk taking behaviour.

Researchers have produced a substantial body of work on the biological and psychological changes that occur during adolescence, as well as the family, peer and cultural influence that shape adolescents, lives in important ways. Current and future efforts to promote healthy behaviour and also to prevent risky behaviours that are prevalent during this stage of development.

Anorexia nervosa has recently become one of common disorder in adolescent girls. A chronic course related to morbidity with one of the most medical complication being severe osteopenia.

An, incidence has risen in the USA and Europe to some things like one in among females of the 15-19 age groups, by now, a phenomenon of ED has assumed a global spread that includes that affluent cast Asian countries, in south America, especially Argentina and child. It has spread to china too.

A most commonly occurs in teenage girls, especially in the pre pubertal age group. The ratio of girls is approximate 10-20:1, about 2% to3% of young women have a clinically important variant of the disorder. There has been a consistent increase in the incidence of an over the past 10 yrs.

In a review of 24 epidemiological studies, reported a prevalence of pure anorexia nervosa of 0.5% young women in western cultures. Reviewing selective studies of case registers found that the annual incident ranged from 14.1 cases/100,000 girls and women aged 10-24 to 43 cases/100,000 girls and women aged 16-24.

Dieting is major risk factor eating disorders. The prevalence of eating disorders in a culture parallels the prevalence of dieting behaviour. In non-western cultures, a low prevalence of both eating disorders and dieting exists, although adolescence of all races who belongs to higher white women in higher socioeconomic classes diet more and are more concerned about their weight than other sub groups of women.

Participation in hobbies and occupations, such as modelling and ballet that promote the ideal of thinners seems to lead to a higher prevalence of eating disorders.

Incidence rates for anorexia nervosa are highest for females aged 15-19 yrs. They constitute approximately 40 years of all identified cases. In Rochester, MN, USN, the incidence rate was 74 per 100000 person years for 15-19-year old females.

In Switzerland the incidence rate of cases admitted for anorexia was 20 per 100,000 person years' females between 12 and 25 yrs. of age during the year 1999. In western countries one-third of the people who meet stringent criteria for anorexia nervosa 6%.

An is mainly affects women, 1 in 250 in the UK as opposed 1 in 4000 men and in fact the female prevalence of AN in some western countries is reported to be as high as 16.7 percentages. A study reported prevalence rates in women in western countries ranged from 5.2 percentages to 9.4 percentages. In non-western countries, the range was 3.4 percentages to 6.3 percentages. But the prevalence in non-western countries seems to be on the rise.

The average age of onset anorexia is 17 years. Those over 40 years of age rarely develop AN. It is developed that 40% of newly identified cases of anorexia are in girls 15-20 years old.

In south west London, on the prevalence rate of anorexia was found to be 20.2 cases per 10,000 populations. Prevalence in female age 15-20 years was 115.4 cases per 10,000 populations. In the annual incidence of anorexia was found to be 15.7 cases per 10,000 total populations. In female aged 15-20 years the incidence rate was 19.2 cases /10,000 populations.

A study was conducted in sample consisted mostly of female adolescents from middle socio economic status towns and villages of north – eastern India. The result indicated that north eastern states of India with a mean age of 15 to 20 years are more prone to anorexia nervosa. The mean age of onset of symptoms and duration was 15.2 years and 19.2 years respectively.

Now a day's more adolescent girls that is age group between 15- 20 years more concerned towards physical maintenance of the body. Adolescents are highly influenced by television and internet with super slim models idolizing them. There is immense emphasis on being thin by the society as well.

STATEMENT OF THE PROBLEM

A study to assess the effectiveness of structured teaching programme on knowledge regarding anorexia nervosa among the adolescent girls in selected college at Sivagangai.

OBJECTIVES

- To assess the level of pretest knowledge regarding anorexia nervosa among the adolescent girls.
- To evaluate the effectiveness of structured teaching programme on knowledge regarding Anorexia nervosa among the adolescent girls.
- To determine the association between pretest knowledge score with their selected demographic variables.

OPERATIONAL DEFINITIONS

- **Effectiveness:**

In this study, it refers to the extent to which the structured teaching program is helpful in gaining knowledge regarding anorexia nervosa in terms of difference between pretest and posttest knowledge measured by semi structured questionnaire.

- **Structured Teaching Program:**

In this study, it is systematically developed programme with teaching aids (LCD), designed to impart knowledge, regarding anorexia nervosa.

- **Knowledge :**

In this study, knowledge refers to the adolescents response to questions related to anorexia nervosa as measured by a semi structured knowledge questionnaire.

- **Adolescent girl :**

In this study, adolescent girl refers to girls who are in the age group between 17 – 19 years studying in the selected college.

- **Anorexia Nervosa :**

It is psychological disorder characterized by a prolonged refusal to eat, resulting in emaciation, amenorrhea, emotional disturbance concerning body image and fear of becoming obese**.**

HYPOTHESES

H1 – There will be significant difference between the mean pre - test and post-test level of knowledge score among adolescent girls on Anorexia nervosa.

H2 – There is a significant association between the pre-test level of knowledge scores of adolescents with their selected demographic variables.

ASSUMPTIONS

- Adolescent girls who are studying in colleges have some knowledge regarding anorexia nervosa.
- Structured teaching programme is an effective method to teach adolescent girls who are studying in a college.
- Girls are commonly having fear about becoming obese.

DELIMITATIONS

The study is limited to

- Students those who were interested to participate in the study.
- Students available at the time of data collection.
- Study focused only on adolescent girls between 17 – 19 years, not other age group.

PROJECTED OUTCOME

This study reveals the existing level of knowledge among the adolescent girls studying in selected A Women's College at Sivagngai. It also will highlight the effectiveness of structured teaching programme on anorexia nervosa among adolescent girls. The result of the study will be strong motivator and will provide irrigate for psychiatric nurses to initiate structured teaching programme in various settings, since it requires minimal resources and cost - effective. Findings of this study will help health professionals to plan structured teaching programme where management is practical and certainly it will add value to psychiatric nursing.

CONCEPTUAL FRAMEWORK

Conceptual framework is a theoretical approach to the study of the problem that is scientifically based and emphasizes the selection, arrangement and classification of its concept. The conceptual framework states functional relationships between events and is not limited to statistical relationships.

The study was intended to assess the effectiveness of structured teaching programme regarding anorexia nervosa among adolescent girls in a selected Women's college, Sivagangai. The present study was based on general system theory which was introduced by Ludwig Von Bertalanffy (1968) with input, process, output and feedback.

According to system's theory, a system is a group of elements that interact with one another in order to achieve the goal. An individual is a system because he/she receives input from the environment. This input when processed provides an input. This system is cyclical in nature and continues to be so, as long as the input, process, output and feedback keep interacting. If there are changes in any of the parts, there will be changes in all the parts. Feedback from within the systems or from the environment provides information, which helps the system to determine whether it meets its goal.

In the present study, these concepts can be explained as follows;

INPUT

The input consists of information material or energy that enters the system. Adolescent girls studying in the selected Women's college is a system and has inputs within the systems itself and acquired from the environment. These input's include learner's background like age, area of residence, type of family, family income, education status of the parents, occupation of the parents, source of previous information, influence the knowledge of adolescent girls.

PROCESS

It refers to the action needed to accomplish the derived task to achieve the desired output, i.e. effectiveness of structured teaching programme regarding anorexia nervosa.

a. Assessment of knowledge of adolescent girls regarding anorexia nervosa.

b. Administration of structured teaching programme.

c. Assessment of knowledge using same questionnaire.

OUTPUT

Output is the behavioural response. Output response becomes feed back to the system and environment. In the present study output is the gain knowledge score. This system achieved through a comparison between mean pre-test and post- test knowledge scores of the samples.

FEEDBACK

It is a process by which information is received at each stage of the system output and its redirection to input. Accordingly the higher knowledge score obtained by adolescent girls indicate that the structured teaching programme was effective in increasing the knowledge regarding anorexia nervosa.

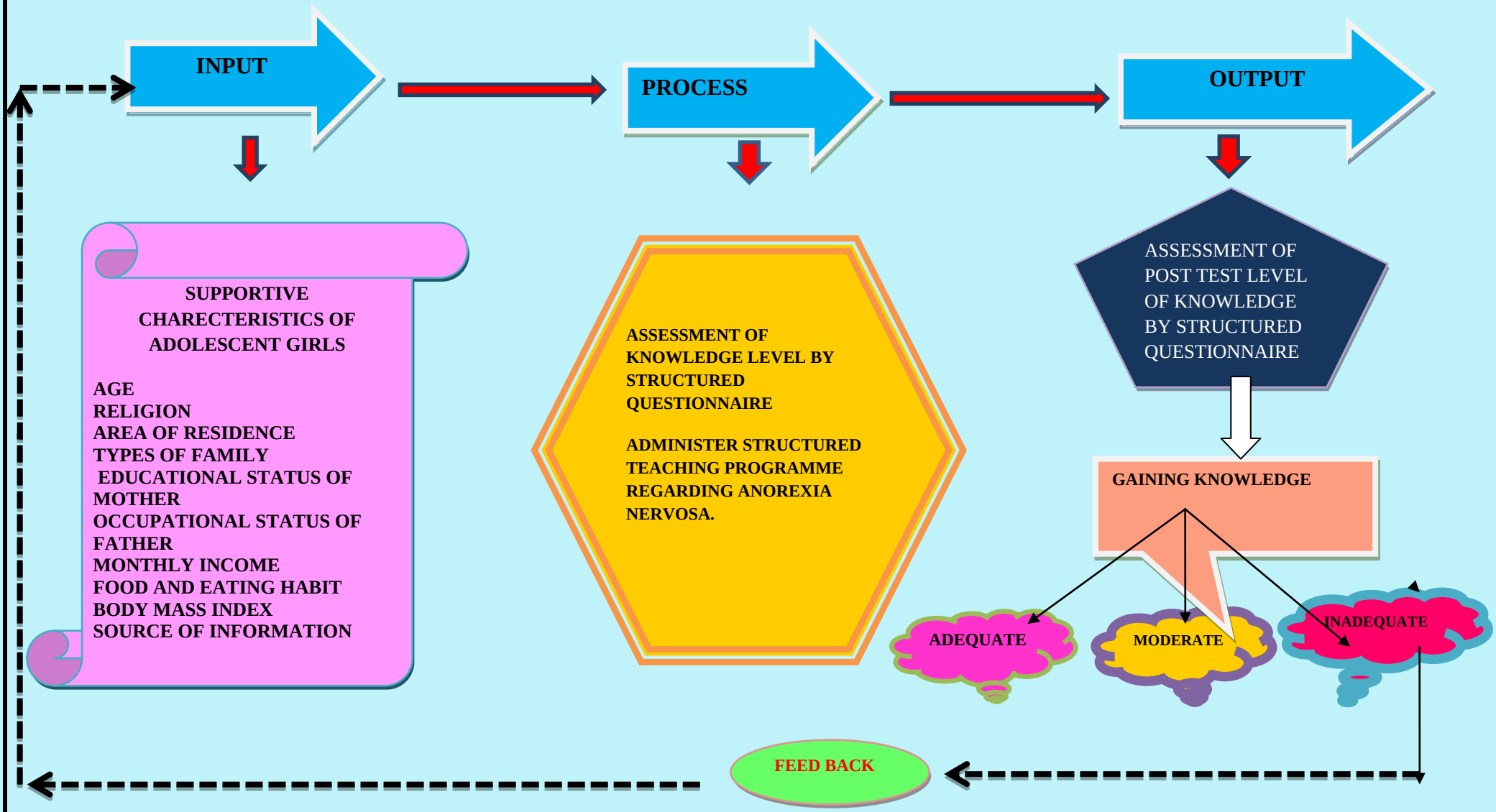


FIGURE 1: CONCEPTUAL FRAMEWORK BASED ON GENERAL SYSTEM MODEL OF VON LUDWIG BERTALANFFY (1968)

CHAPTER – II

REVIEW OF LITERATURE

CHAPTER 11

REVIEW OF LITERATURE

Review of literature is an important step in the development of any research project. It involves the systemic identification, location, scrutiny, and summary of written materials that contain information on research problems. It enhances the depth of knowledge and inspires a clear insight into the crux of the problem. Literature review throws light on the studies and their findings reported about the problem under study.

The available literature and studies are organized under the following headings.

- Studies and literature related to anorexia nervosa
- Studies and literature related to impact of anorexia nervosa in adolescent girls.
- Studies and literature related to risk factors, prevention, management on anorexia nervosa

Studies and literature related to anorexia nervosa:

Stein glass J, (2015) a study was investigating, inadequate intake and preference for low- calorie foods are salient behavioral features of Anorexia nervosa This study aimed to develop a new paradigm for experimentally modeling maladaptive food choice in AN. Individuals with AN (n=22) and healthy controls (HC, n=20) participated in a computer based Food Choice Task, adopted for individuals with eating disorders. Participants first rated 43 food images (including high- fat & low- fat items) for Healthiness and Tastiness. The result is the anorexia nervosa group was less likely to choose high fat foods relative to HC, as evidenced both in multilevel logistic regression ($z = 2.59$, $p = .009$) and ANOVA ($F (1, 39$ anorexia nervosa$) = 7.80$, $p = .008$) analyses. Health ratings influenced choice significantly more in anorexia nervosa relative to HC ($z = 2.7$, $p= .006$). The findings suggest that the experience of tastiness changes overtime and may contribute to perpetuation of illness. By providing experimental quantitative measure of food restriction , this task opens the door to new experimental investigations into the

cognitive, affective, and neural factors contributing to maladaptive food choices characteristics of AN.

Stenhausen HC, (2015), a study conducted to investigating how often anorexia nervosa (AN) and co- morbid disorders occur in affected families compared with control families. A total of N = 2,370 child and adolescent psychiatric subjects born between 1951 and 1996 and registered in the Danish Psychiatry Central Research Register (DPCRR) had any mental disorder before the age of 18 and developed AN at some point during their life- time. AN occurred significantly more often in control families. Anorexia nervosa risk factors included having a sibling with AN, affective disorders in family members, and co- morbid affective, anxiety, obsessive-compulsive, personality, 0r substance use disorders. Furthermore, female sex, and ascending year of birth were significantly associated with having AN. Urbanization was not related to the family load of anorexia nervosa and case relatives did not develop AN earlier than control relatives.

Tolgyes T, (2014) a study conducted to investigating the prevalence rates of anorexia nervosa in North America and Western Europe , carried out as a screening examination and a semi- structured diagnostic interview was conducted. Of the overall female samples, 3% revealed anorexic disposition, but no actual cause of anorexia nervosa were detected. 25% of the ballet students corresponded to the criteria of anorexia. They conclude that Body ideal of thinness in young women has a significant effect of self- esteem. The prevalence rate of adverse eating behaviors in Hungary has been found to be similar to the score published in the western countries.

King JA, (2014) a study conducted to assess the serious eating disorder characterized by self- starvation, extreme weight loss, and alterations in brain structure. Structural magnetic resonance imaging studies have documented brain volume reductions in acute AN, but it is unclear. So Structural magnetic resonance imaging data were acquired from adolescent and young adult female patients with acute AN (n=40), recovered patients following long term weight restoration (n=34), and an equal number of age - matched healthy control subjects. result is Vertex- wise analyses revealed significant thinning of over 85% of the cortical surface in patients with acute AN and CT normalizations in recovered patients following long term weight restoration patients, although normal age related trajectories were absent in

disorder. This study concludes that Structural brain anomalies in AN as expressed in CT and sub cortical volume are primarily the consequence of malnutrition and unlikely to reflect pre morbid trait markers or permanent scars.

Ben-Dor DH, (2012) a study conducted to examining the prevalence on anorexia nervosa among the relatives. Prevalence is estimated at 1/1000, but with a high prevalence of the partial syndrome and a mortality rate. This article reviews the findings of concerning the heritability and the contributing genes of the disorder, a higher frequency of an anorexia nervosa was found among the relatives . The heritability rate was estimated at 0.71, similar to twin's studies, which estimate 0.58-0.76. They conclude, although there is a strong familial component in anorexia nervosa. As well as sub typing the different types of AN, will bring us closer to understanding of the heritability of anorexia nervosa and enable the development of improved means of prevention and treatment Hewitt PL, (2011) a study conducted to assessing the characteristics of individual who died from anorexia nervosa in the USA. Data from 10 million death records (all National Center for Health Statistics registered death in USA) were examined for mention of anorexia nervosa as a primary contributing cause of death. Only 724 were found which equals an average of 145 annual deaths and ate of 6.73 per 100,000 deaths. The age and sex distribution suggests 2 fatal forms anorexia nervosa, an early onset form comprising 89% of women age of 15 -35 yrs. and a later form comprising 24% men. The findings suggest the mortality risk of anorexia nervosa is confined to young adults and adolescents.

Muro- Sans P, (2011) a study conducted to describing the prevalence of anorexia nervosa among Spain adolescents. A community sample of 1155 participants, and a risk sample of 93 participants, aged between 10.9 and 17.3 years old from the city of Barcelona participated in the study. A study involves screening with a structured clinical interview method. They conclude that a 1.28 % of the total sample was detected as anorexia nervosa (2.31% of girls and 0.17 % of boys.) Symptoms of anorexia nervosa were higher among girls than boys. Preoccupation with maintained low weight, with body image and shape and taking excessive exercises in order to lose weight, are increasing among Spanish adolescent girls.

Isomaa R, (2011) a study conducted to investigating the prevalence, incidence and development of eating disorders and subclinical eating pathology. A study was

conducted in Western Finland with 595 adolescents. A screening questionnaire followed by a semi structured interview was used to determine the prevalence, incidence and development of eating disorders. The lifetime prevalence rates for females age 18 were 2.6 % for anorexia nervosa (AN), 0.4% for bulimia nervosa (BN) ,7.7% for AN- NOS,1.3% for BN-NOS and 8.5 subclinical eating disorder. No prevalent case of DSM-IV eating disorders was found among the males. The incidence rate of eating disorder in adolescents age 15 - 18 was 1641 per 100 000 person per year.

A study was conducted in Tamil Nadu, India about the prevalence and psychiatric co- morbidity among juvenile with eating disorder 41 cases with ICD 10 diagnosis of eating disorder 25% psychogenic vomiting was the commonest eating disorder and anorexia nervosa the emerging eating disorder.

Studies and literature related to impact of anorexia nervosa in adolescent girls.

Torres S, (2015) a study conducted to assessing the role of depression of alexithymia in anorexia nervosa (AN) has been controversy explained and several variables that mask or increase the presence of emotional difficulties. The Toronto Alexithymia Scale (TAS- 20) and the Zung- Self Rating Depression Scale were administered to 160 females.80 participants with anorexia nervosa, 80 Healthy Controls. Alexithymia is a relevant feature thought the spectrum of AN, and the patient has a cognitive- affective disturbances in AN.

Frank GK (2015) over the past decade, brain imaging has helped to better define eating disorder - related to brain circuitry. Brain research on grey matter (GM) and white matter (WM) volumes had been inconsistent, possibly due to the effect of acute starvation, exercise, medication, and co morbidity. Brain imaging that targeted dopamine related brain activity using taste reward conditioning tasks suggested that is circuitry is hypersensitive in anorexia nervosa, and hypo responsive in bulimia nervosa and obesity.

Corbetta F, (2015) a study conducted to assessing plasma levels of vitamin B12 and folates with respect to liver function enzymes considering the liver storage properties of this vitamin. 70 restrictive type AN adolescents and the severity of psychological traits was assessed using EDI - 3 Scale. Plasma levels of vitamin B12,

folates, transaminases (AST, ALT), gamma - glut amyl Transpeptidase, (GGT), alkaline phosphate (ALP), and Cholinesterase (CHE) were determined. About 38.5% of patients displayed vitamin B12 values (H- B12) above the upper range of normal reference. 4.3% of patients had increased values of folates; 20 and 11.4% of patients displayed ALT and AST values above reference limits. None had GGT limit values above normal. These data suggest that plasma levels of vitamin B12 might be an early marker of liver dysfunction, possibly also related to more severe psychopathological aspects.

Nacinovich R, (2015) an exploratory study conducted to assessing α β plasma levels in anorexia nervosa patients. A total 24 adolescent female AN outpatients were recruited with 12 age comparable healthy controls. For each subject assessed α β 40 and leptin plasma levels, as well as APOE gene type. Plasma α β 40 levels were similar between patients and controls, while a marked reduction was observed for leptin (-80%) in anorexia nervosa patients. α β 40 plasma levels failed to correlate with leptin, while a linear correlation was present with HCY ($r = 0.50$, $p<0.03$). This study shows that a significant role for altered α β production in AN- associated dysfunctions.

Bomba M, (2014) a study conducted to investigating the deficits in autobiographical memory in adolescents with anorexia nervosa (AN). An experimental study for 60 female with anorexia nervosa and 60 Healthy volunteers with an age range of 11 - 18 years were enrolled. The Autobiographical Memory Test (AMT), the Eating disorder inventory -3, The Toronto Alexithymia Scale (TAS-20), for the evaluation of alexithymia and children depression Inventory to evaluate depressive traits was administered. Girls with anorexia nervosa showed a Massive over general memory effect. This effect was not related to the presence of depression or alexithymia but increased with the duration of the disorder rather than with its severity.

Roux H, (2013) a study was conducted to finding the impact on interpretation of results on anorexia nervosa. The incidence of female cases is low in general medicine o specialized consultation in town, from 4.2 and 8.3/100,000 individuals per year. It is much higher in the general population, ranging from109 to 270/100,000 individuals per year. In fact , the studies reporting variations in the incidence of AN

were conducted on samples from clinical population in certain countries (United States and United Kingdom) On average , 4.7 % of the individuals treated for AN recovered, 34% improved,21% had chronic eating disorder , and 5 % died. Mortality rate varies according to the population considered. Rates observed are 6.2 t0 10.6 times greater than the observed in the general population for a follow up duration ranging respectively 13 to 10 years. Only 3.7 times more frequent than in the general population for follow - up periods of 20- 40 years. It appears lower for subjects treated before the age of 20. The main causes of death are eating disorder complications, suicide and cancer.

J Affect Discord (2010) a study conducted to examining the competing explanations of the high rate of death by suicide among adolescents with anorexia nervosa. 9 case reports of adolescents died with anorexia nervosa. The findings converged with the later hypothesis, as predicted by Joiner's (Joiner, T, 2006. Why people die by suicide. Harvard University press, Cambridge, MA) theory of suicide which suggests adolescent with anorexia nervosa may habituate to the experience of pain during the course of their illness and accordingly die by suicide methods that are highly lethal.

Studies and literature related to risk factors, prevention, and management on anorexia nervosa;

Ciao AC (2015) a study conducted to examining the family functioning in two treatments for adolescent AN from multiple family members perspectives.120 adolescents with AN ages 12- 18 from a randomized - controlled trail comparing family based treatment (FBT) to individual adolescent - focused therapy (AFT). Multiple clinical characteristics were assessed at baseline. Families seeking treatment for adolescent anorexia nervosa reported some difficulties in family functioning, with adolescents reporting the greatest impairment.

Hofer M, (2014) a study to examining the complications due to re -feeding of patients with anorexia nervosa, as well as their mortality rate after the implementation of guidelines from the European Society of Clinical Nutrition and Metabolism.The sample consist of 65 inpatients, 14 were admitted more than study period, resulting in 86 analyzed cases. Minor complications with re feeding during the first 10 days were

9 cases (10.5%), 4 with transient peri orbital edemas, and 3 with organ dysfunction, and 2 cases with severe hypo kalemia occurred during observational period 30 days 16 minor complications occurred in 14 cases (16.3%). 6 infectious and 10 non - infectious complications occurred. The findings indicate guidelines are able to reduce complications and prevent mortality.

Gale CJ, (2013), a study conducted to examining the father in the development in child and adolescent psychopathology. Research findings shows that family influence and the value of family - based interventions, this article reviews the potential impact of the father- child relationship on the development and maintenance of Anorexia nervosa in young people.13 studies met inclusion and exclusion criteria and were critiqued, with 8 being forward for discussion. This 8 studies identified key themes within the relationship of the father - child relationship particularly daughters, around conflict and communication, parental protection, psychological control, emotional regulation, self - esteem, and self-perfectionism. All of these factors appear to influence child's level can impact of maladaptive eating habits and psychopathology.

Lowe B, (2013) a study conducted to investigating the long term outcome and prognosis in an anorexic sample 21 yrs. after the initial treatment. A multidimensional and prospective design was used to assess outcome in 84 patients 9 yrs. after a previous follow up and 21 yrs.' after admission. Among the 70 living patients, the follow up rate was 90%. Causes of death for the deceased patients were obtained through the attending physician. 51% of patients were found to be fully recovered at follow up, 21% were partially recovered and 10 % still met diagnostic criteria for anorexia nervosa, 16% were deceased due to causes related to anorexia nervosa. This study was concludes that recovery is still possible for anorexia nervosa patients after a period of 21 yrs.

Wick K, (2011) a study conducted to assessing the real world effectiveness of a German school based interventions for primary prevention of anorexia nervosa in pre-adolescent girls. Anorexia nervosa is notoriously difficult to treat, has high mortality rates and has a prevalence peak in 15- year old girls. Intervention involved 9 guided lessons with special posters and group discussions. A parallel controlled with pre- post measurements and a three month follow up was conducted in 92 Thuringian

schools (n = 1553 girls) in 2007 and 2008. Primary outcomes were conspicuous eating behavior, body self- esteem, and AN - related knowledge. After the primary interventions provides an efficient and practical model to increase AN- related protection factors.

Gordon SM, (2010), a study conducted to assessing the treatment of co-occurring eating disorders in publicity funded addiction treatment programs in African- American patients. Data were collected between 2002 and 2004 from face to face interview with nationally representative sample of 351 addiction treatment programs. In this 29% admit all persons with eating disorders, and 48% of persons with eating disorders of low severity. These results highlight the need for education of addiction treatment professionals in assessment of eating disorders.

CHAPTER – III

RESEARCH METHODOLOGY

CHAPTER III

METHODOLOGY

This chapter deals with the methodology adapted by the investigator to assess the effectiveness of structured teaching programme on Anorexia nervosa and among adolescent girls in selected college at Sivagangai. It deals with research approach, research design, setting of the study population, criteria of the sample, selection sample size, sampling technique, development of tool for data collection and plan for data analysis.

RESEARCH APPROACH:

An evaluatory approach was adopted by the investigator to find the effectiveness of structured teaching programme Anorexia nervosa.

RESEARCH DESIGN:

The investigator adopted Pre-experimental, one group pretest post- test design to this study.

Group	**Pre-test knowledge**	**Treatment STP**	**Post-test knowledge**
100 selected sample of adolescent girls	O_1	X	O_2

O_1: Pre assessment level of knowledge

X: Treatment

O_2: Post assessment level of knowledge

VARIABLES:

- Independent variable**:** Structured teaching programme is the independent variables of this study.
- Dependent variable**:** In this study dependent variable was knowledge score.

SETTING OF THE STUDY:

The study was conducted in Madurai Sivakasi Nadar's Pioneer Meenakshi Women's College, Poovanthi, Sivagangai. Approximately 1000 students are studying in this college. Among them 250 students are B.sc 1st year students in this college. The college has adequate facilities like electricity, water and transportation facilities.

STUDY POPULATION:

In this study, study population selected was all the adolescent girls those age group between 17-19 years in selected college at Sivagangai.

SAMPLE:

The samples selected were 100 adolescent girls from the selected Women's College at Sivagangai.

SAMPLE SIZE:

The sample for the present study consisted of adolescent girls, who met the inclusion criteria.

SAMPLING TECHNIQUE:

The investigator adopted purposive sampling technique to select the samples for this study.

CRITERIA FOR SAMPLE SELECTION:

The sample was selected based on the following inclusion and exclusion criteria.

Inclusion criteria:

- Who are willing to participate in this study
- Who are available during the period of data collection
- Study focused only on adolescent girls between 17-19 years, not other age group.

Exclusion criteria:

- Who are studying B.Sc II yr or III yr
- Who are willing to participate in this study.

DEVELOPMENT AND DESCRIPTION OF THE TOOL:

The investigator prepared an assessment tool after reviewing literature to assess effectiveness of structured teaching programme on Anorexia nervosa and considering the opinion of medical and nursing subject experts.

The tool consists of two parts.

Part I contains the following sections

- Section A : Demographic variables
- Section B : Structured questionnaire

CONTENT VALIDITY:

Assessment tool was given to five experts in the field of nursing for content validity. Suggestions were considered and appropriate changes were done.

RELIABILITY:

The data were collected from 10 samples to find out the reliability. The split half method was used to establish the reliability of the tool. This was done by splitting the items into odd and even items. Using these values Karl's Pearson correlation co-efficient was computed ($r = 0.75$) of the whole test was then estimated by spearman Brown Prophecy formula and value obtained was $r = 0.75$, which indicates that tool is reliable.

PILOT STUDY:

Pilot study was conducted for the period of one week on 10 adolescent girls in order to test the feasibility, relevance and practicability of the study. Results showed that study was feasible to carry out the study in the same setting.

DATA COLLECTION PROCEDURE:

A formal prior permission was obtained from the Chairman, Principal of the college by submitting an application and giving assurance to abide by the rules and regulation that no personal and professional inconvenience would be created because of the study similarity Head of the Department of Mental Health Nursing was explained about the purpose of the study of permission was obtained.

The study was conducted for period of one month. The investigator selected the sample who are fulfilled the inclusion criteria. The investigator explained the purpose of the study in a compassionate manner and informed consent was obtained. The investigator was taken care to look in to their convenience and comfort. Data were collected from adolescent girls to assess their level to knowledge. Score by using structured questionnaire before administration of structured teaching programme adolescents were assessed by their score knowledge level.

PLAN FOR DATA ANALYSIS:

Collected data was analyzed by descriptive and inferential statistics. Student't' test was used to compare the effectiveness of structured teaching programme. Chi-Square test was used to final the association between demographic variables with level of knowledge regarding Anorexia nervosa.

PROTECTION OF HUMAN RIGHTS:

Research proposal was approved by the dissertation committee, RASS Academy College of Nursing, Poovanthi. Prior to the study oral consent from each adolescent girls was obtained before starting the data collection. Assurance was given to the adolescent girls that confidentiality would be maintained.

CHAPTER- IV

DATA ANALYSIS

CHAPTER - 1V

ANALYSIS & INTERPRETATION OF DATA

This chapter deals with the analysis and interpretation of data collected from the samples. Data collected were tabulated, analyzed and presented. It consists of the following sections.

Section I **:** It deals with distribution of samples according to the demographic variables.

Section II **:** It deals with description of sample according to their pre test and post test level of knowledge

Section III **:** It deals with comparison of pretest and posttest knowledge level among Adolescent girls.

Section IV **:** It deals with the association of pretest knowledge level and Selected Demographic variables

.

SECTION -I

Distribution of sample according to demographic variables of the adolescent girls.

Table 1: Distribution of sample according to demographic variables of the adolescent girls

Item	Demographic variables	Frequency(f)	Percentage (%)
a.	**Age in years**		
	17 – 18	67	67
	18 – 19	33	33
b.	**Religion**		
	Hindu	91	91%
	Christian	4	4%
	Muslim	5	5%
c.	**Type of family**		
	Nuclear	57	57%
	Joint	35	35%
	Extended	8	8%
d.	**Area of residence**		
	Rural	64	64%
	Urban	27	27%
	Slum	9	9%
e.	**Mother's education status**	8	8%
	Illiterate	44	44%
	High school	32	32%
	Higher secondary	12	12%
	Under graduate	4	4%
	Post graduate		
f.	**Occupation**		
	Un employed	0	0%
	Self employee	70	70%

	Private employee	21	21%
	Government employee	9	9%
g.	**Income of the family**		
	Below Rs 5000	31	31%
	Rs.5001 – 10000	50	50%
	Rs.10001 – 15000	13	13%
	Above Rs. 15000	6	6%
h.	**Habit of Food pattern**		
	Vegetarian	33	33%
	Non – Vegetarian	67	67%
i.	**Type of food pattern**		
	Fatty meals	24	24%
	Junk foods	50	50%
	Balanced diet	6	6%
	Normal diet	20	20%
j.	**No of meals pattern per day**		
	1 time meals/ day	37	37%
	2 times meals/ day	32	32%
	3 times meals/ day	12	12%
	More than 3 times/ day	19	19%
k.	**Source of information about anorexia nervosa**		
	Family members	05	05%
	Friends	05	05%
	Mass media	06	06%
	No information	84	84%
l.	**Body Mass Index**		
	Low weight	25	25%
	Normal	65	65%
	Over weight	08	08%
	Obesity	02	02%

TABLE 1 shows that, with regards to age 67 (67%) were 17- 18 yrs, 33(33%) were 18- 19 years of age. With regard to religion majority of the samples 91 (91%) were Hindus, 4 (4%) were Christians and 5 (5%) of them were Muslims. With regard to the area of residence, majority, 64 (64%) resides in rural area, 27 (27%) reside in urban area, 9 (9%) reside in slum area. Family system of adolescent girls reveals 57 (57%) were from nuclear family, 35 (35%) were joint family, and 8 (8%) were extended family. distribution of subjects with reference to educational qualification of mother reveals majority 44 (44%) were belongs to High school, 32 (32%) were belongs to higher secondary, 12 (12%) were under graduates and 4 (4%) of them were post-graduation and 8 (8%) were illiterate. With regard to occupation of father reveals majority 70 (70%) were self-employees, 21(21%) were private employees, 9(9%) of them were government employees, and no one in unemployed. With regard to family income majority of the adolescent girls 50 (50%) belongs to the income level 5000 -10,000 per month, 31 (31%) belongs to below 5000 per month, 13 (13%) were receiving 10,000- 15,000/%, and 6 (6%) of hem receiving above 15,000/month. With regard to habit of food pattern of adolescent girls majority 67 (67%) non - vegetarian, 33(33%) of them were belongs to vegetarian. Distributions of subjects with type of food pattern of adolescent girl's majority 50 (50%) were having junk foods, normal diet, 24 (24%) were having fatty meals, 20 (20%) were having normal diet, and 6(6%) of them were having balanced diet. With regard to number of meals pattern per day of adolescent girl's majority 37(37%) of them taking 1 time meals per day, 32(32%) of them taking 2 times meals per day,12 (12%) of them taking 3 times meals per day, 19(19%) of them taking more than 3 times per day. Distribution of subjects with reference to previous information regarding anorexia nervosa shows majority 84 (84%) of them not received any information about anorexia nervosa,5(5%) had received information from family members, 5(5%) had received information from friends, and 6(6%) of them received information from mass media. With regards to body mass index of adolescent girls majority 65(65%) of them are having normal body weight, 25(25%) of them are having low weight 8 (8 %) of them are having over weight and,2 (2%) of them are having obesity.

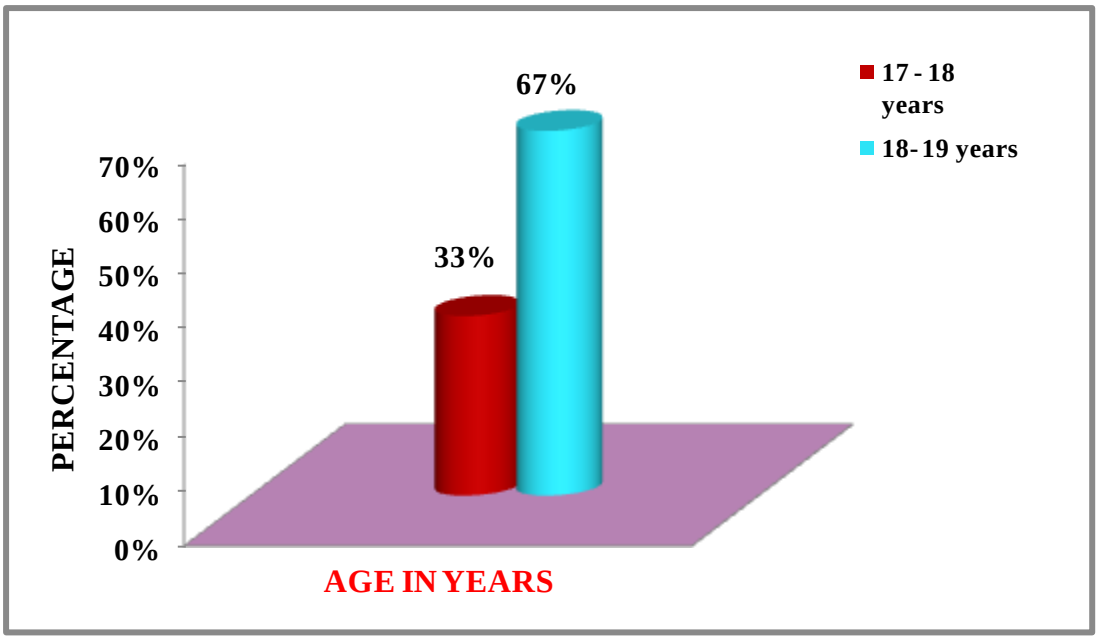


Figure 2: Distribution of the adolescent girls according to their age

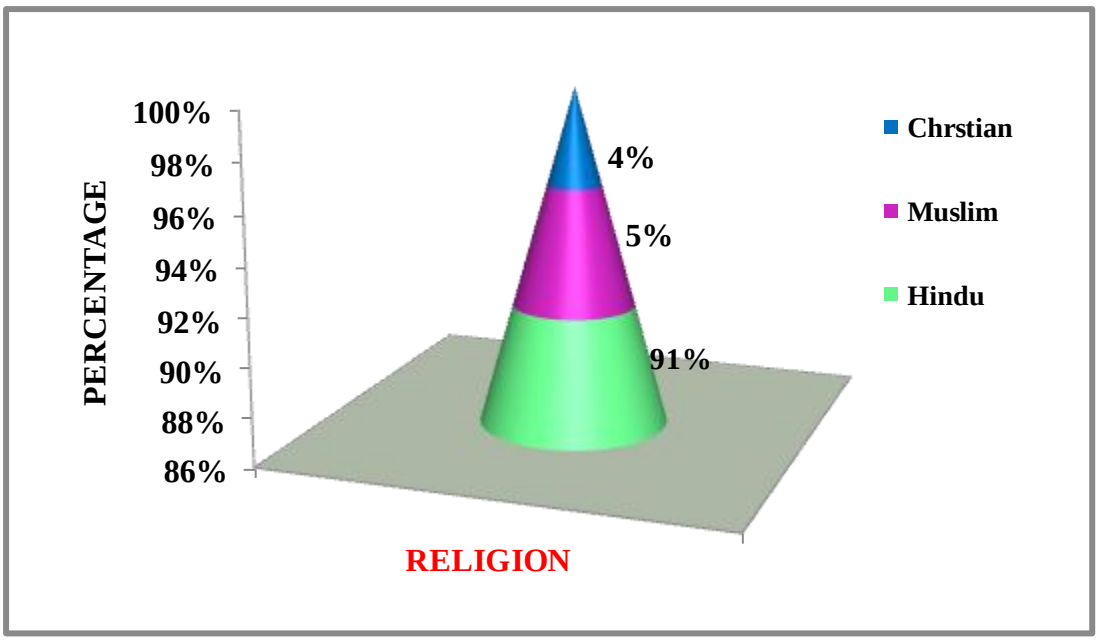


Figure 3: Distribution of the adolescent girls according to their religion.

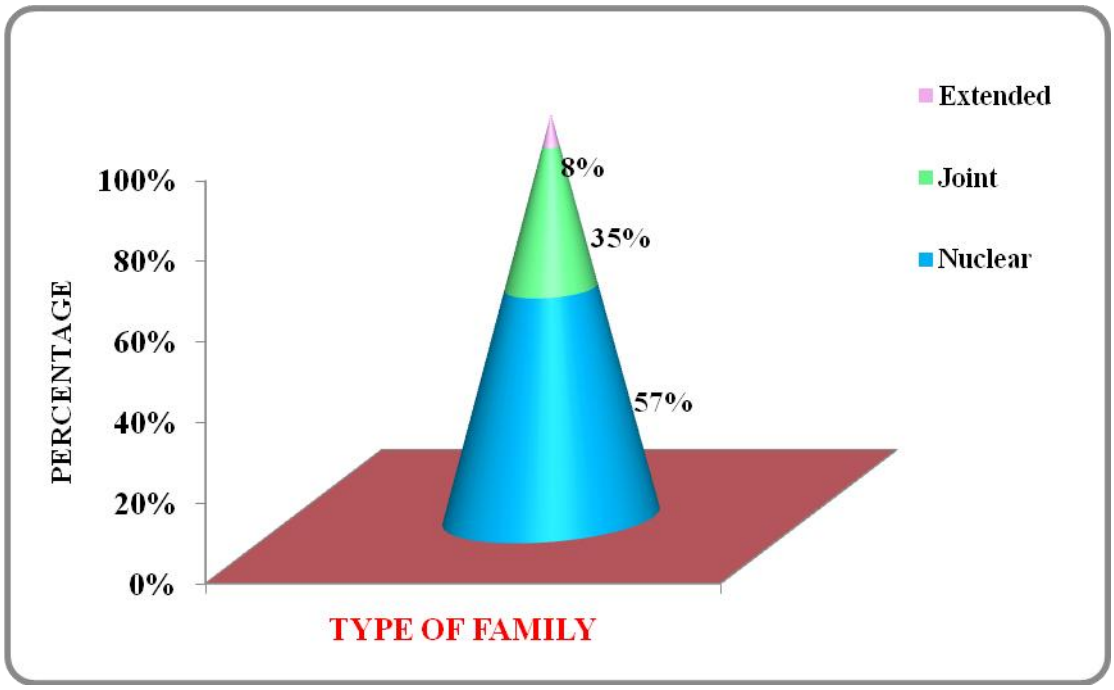


Figure 4: Distribution of the adolescent girls according to the type of family

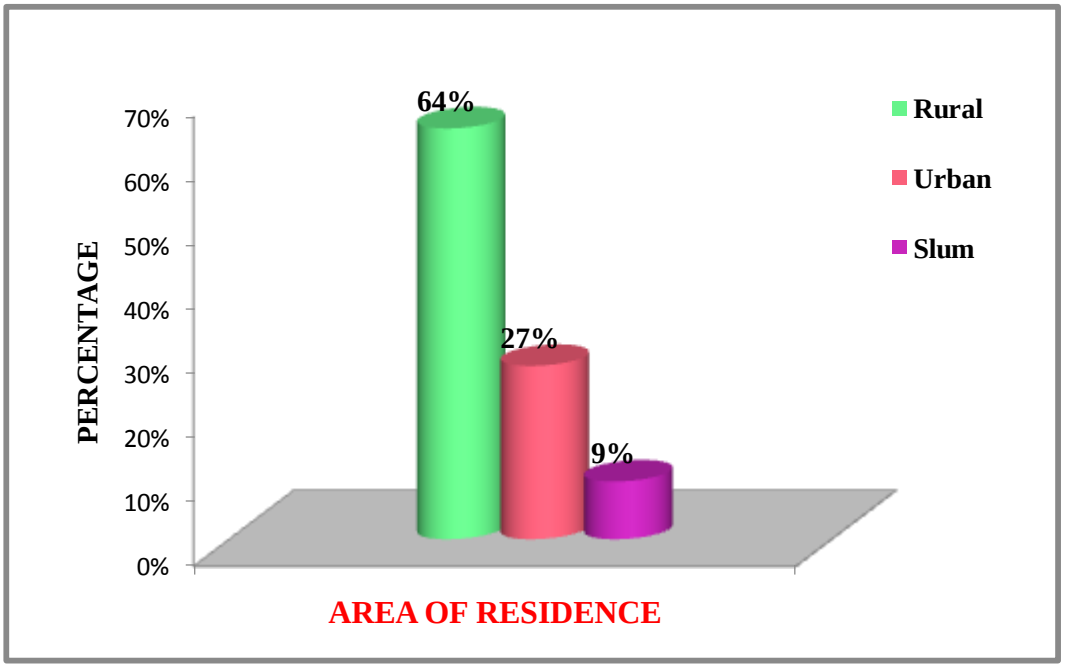


Figure 5: Distribution of the adolescent girls according to their area of residence

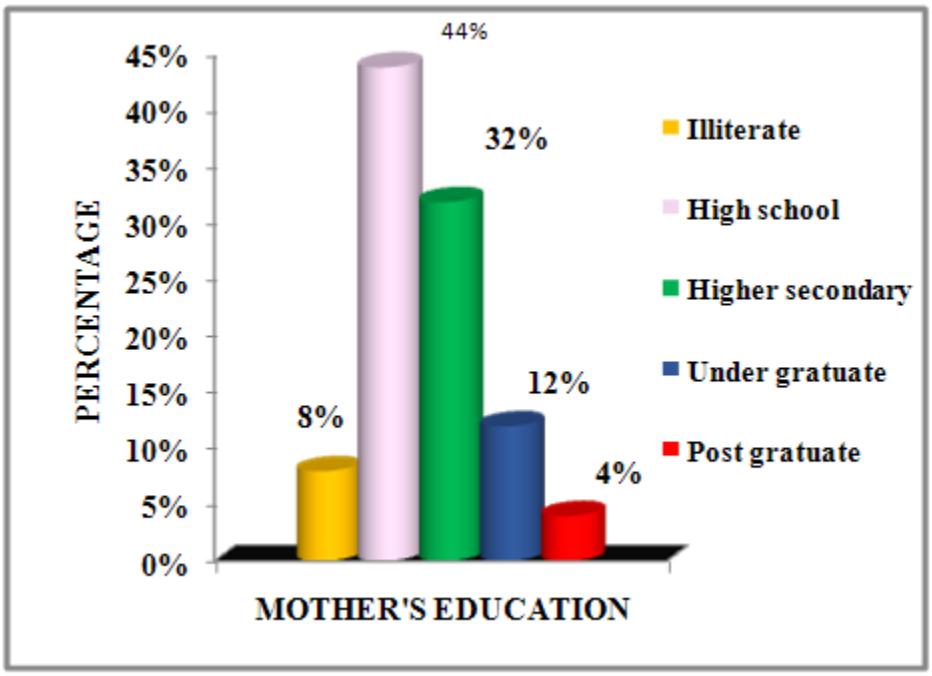


Fig. 6: Distribution of adolescent girls according to their mother's educational status.

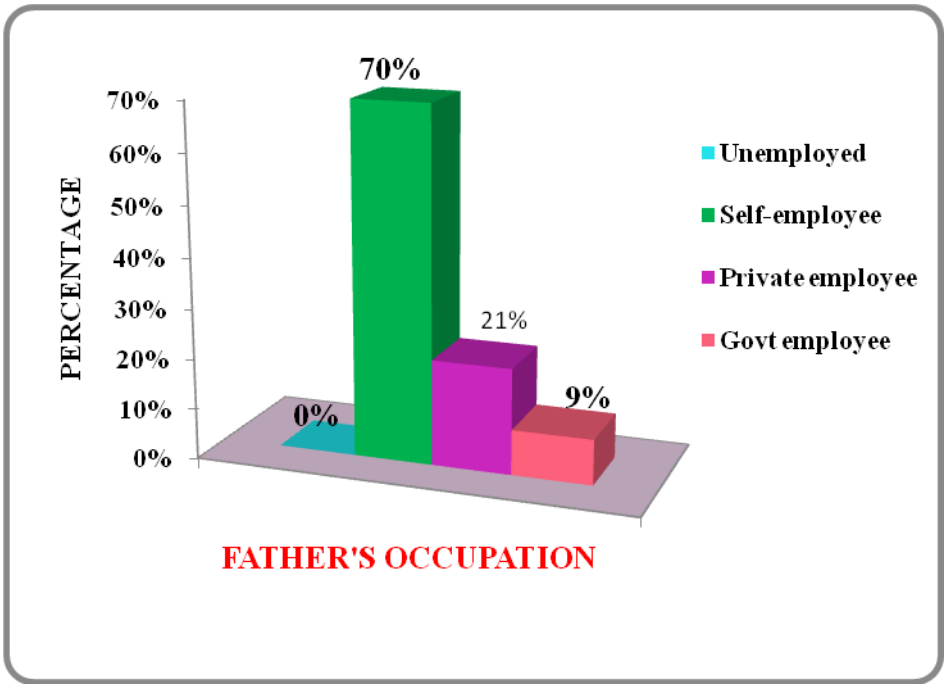


Figure 7: Distribution of the adolescent girls according to their Father's occupation

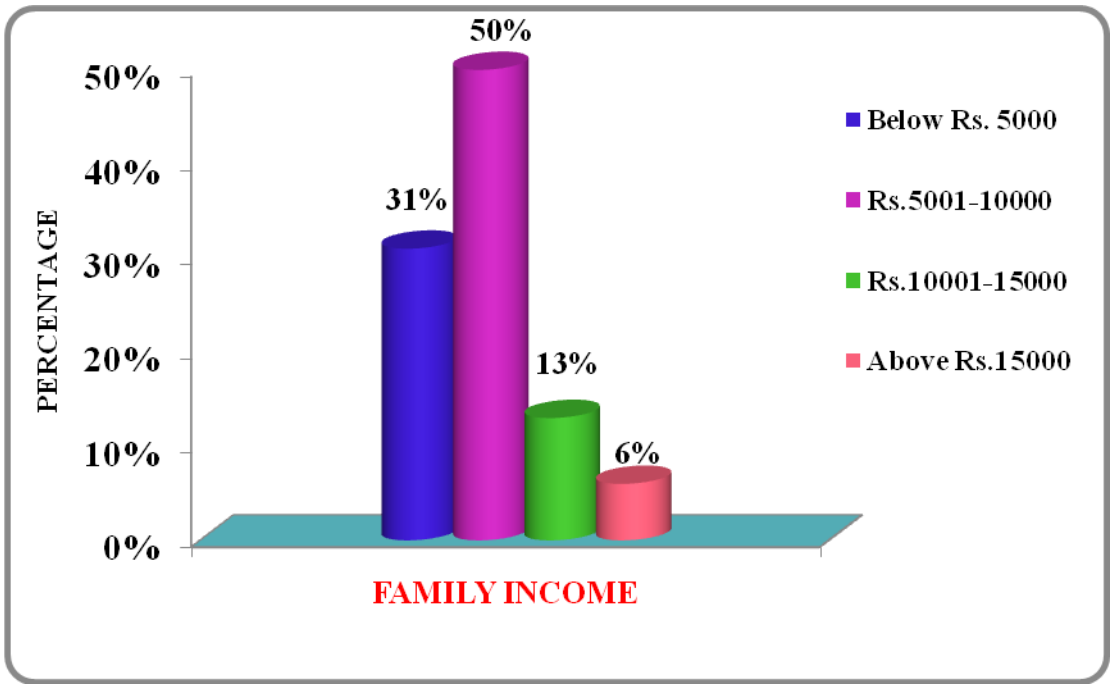


Figure 8: Distribution of the adolescent girls according to their family income

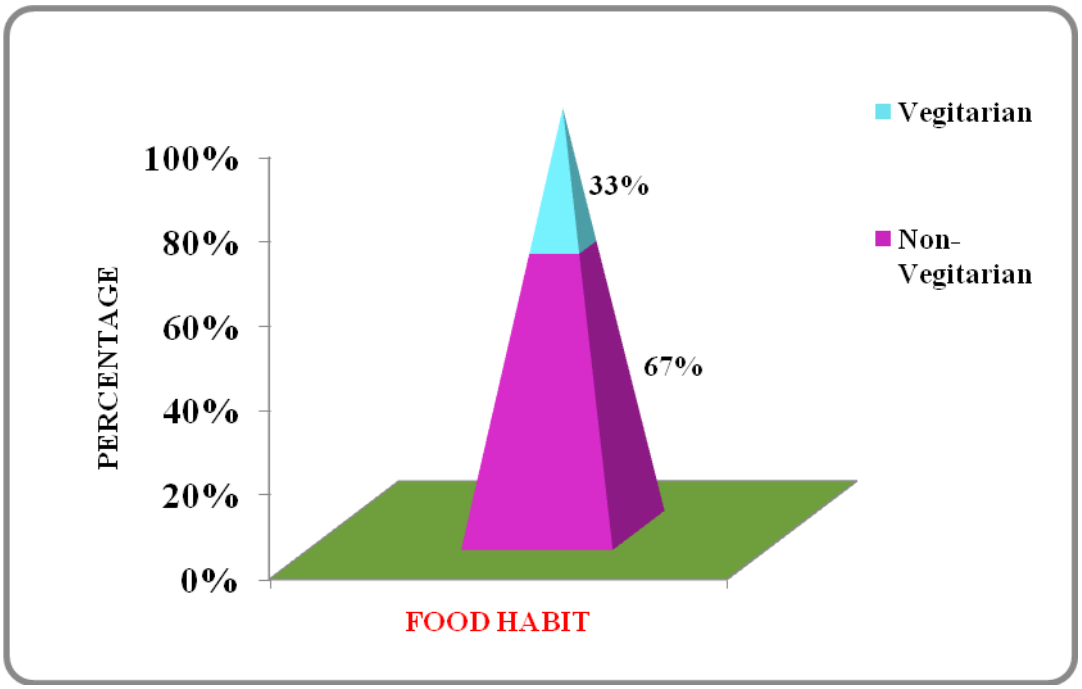


Figure 9: Distribution of the adolescent girls according to their food habit

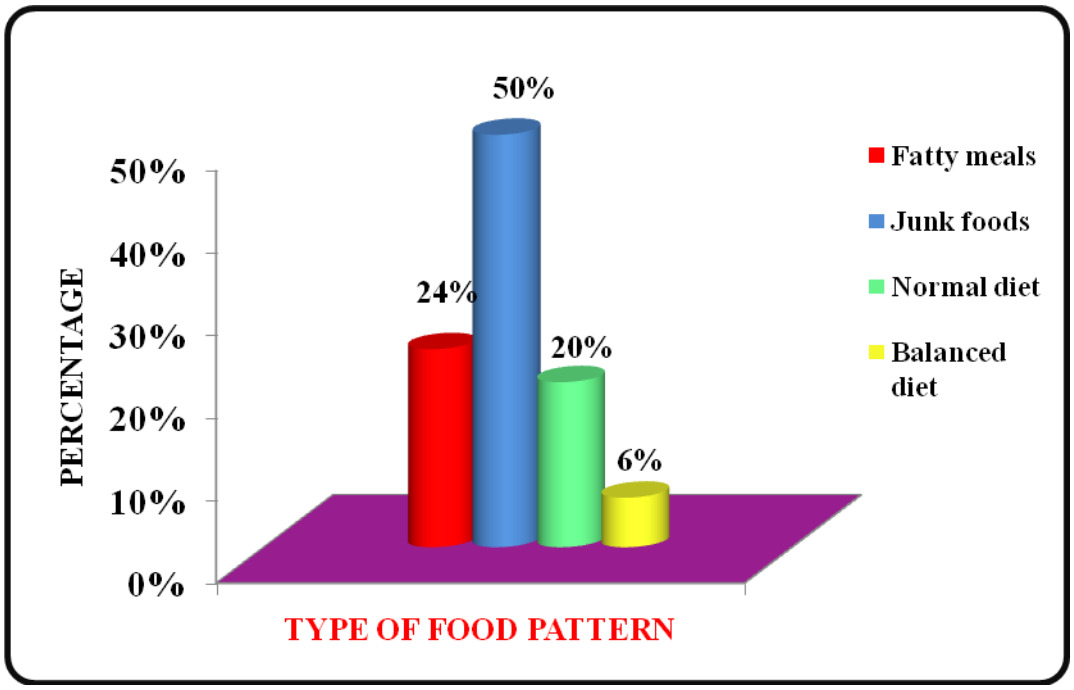


Figure 10: Distribution of the adolescent girls according to their type of food pattern.

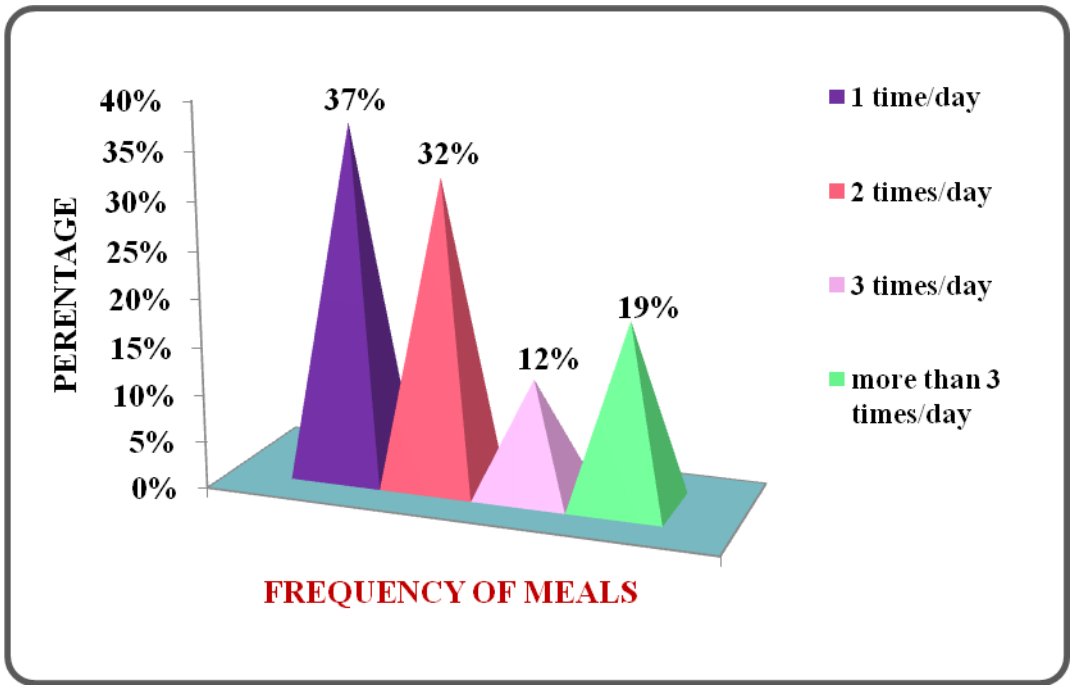


Figure11: Distribution of the adolescent girls according to their Frequency of meals pattern

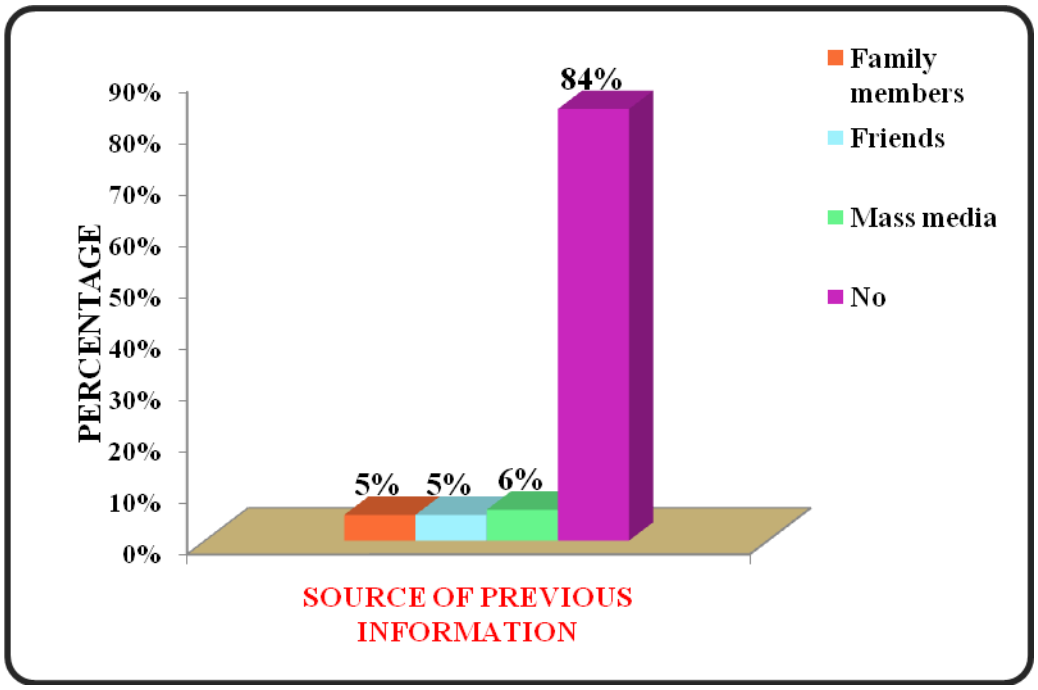


Figure 12: Distribution of the adolescent girls according to source of previous information about anorexia nervosa.

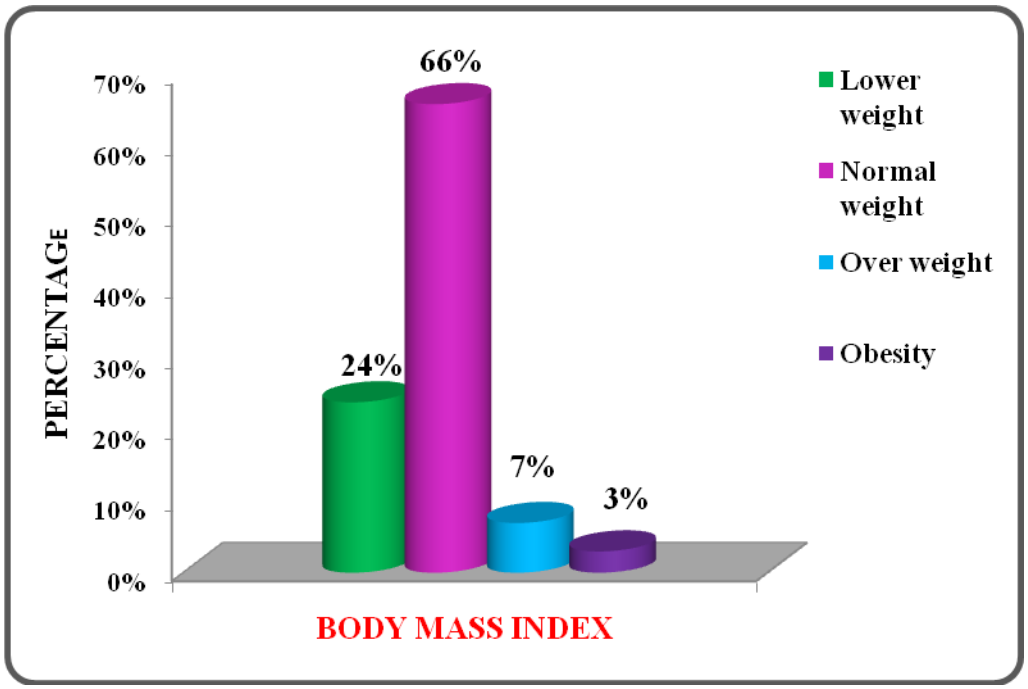


Figure 13: Distribution of the adolescent girls according to their Body Mass Index

SECTION –II

Description of samples according to their pretest and posttest level of knowledge regarding anorexia nervosa.

Table 2: Distribution of adolescent girls according to the pretest and posttest level of knowledge.

n = 100

Level of knowledge	Pre – test		Post – test	
	Frequency (f)	Percentage (%)	Frequency (f)	Percentage (%)
Inadequate	80	80%	0	0%
Moderate	20	20%	4	4%
Adequate	0	0%	96	96%

Table 2 depicts that to assess the pretest and posttest level of knowledge regarding anorexia nervosa. Majority 80 (80%) of adolescent girls had inadequate knowledge regarding anorexia nervosa, and 20 (20%) of adolescent girls had moderate level of knowledge about anorexia and no one had adequate knowledge about anorexia nervosa in the pretest. Majority 96 (96%) of adolescent girls had adequate knowledge about anorexia nervosa, 4 (4%) of them had 4 (4%) moderate level of knowledge about anorexia nervosa, and none of them are had inadequate knowledge regarding anorexia nervosa in the posttest.

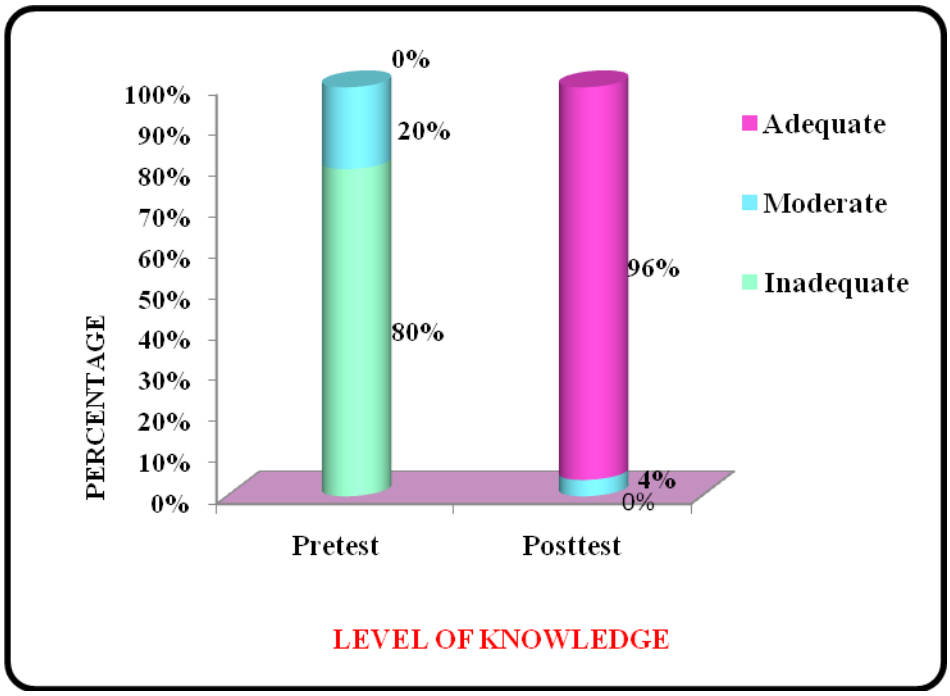


Figure 17: Distribution of adolescent girls according to the pretest and posttest level of knowledge.

SECTION –III

Comparison of pretest and posttest knowledge level of adolescent girls regarding anorexia nervosa.

Table 3: Comparison of mean pretest and posttest knowledge level of adolescent girls.

n = 100

S.No	Level of knowledge	Mean	Mean difference	SD difference	"t" Value
1.	Pretest	12.22	13.81	2.036	44.54
2.	Posttest	26.03		2.457	

P<0.05

Table 3 predicts that comparison of the mean pretest and post -test level of knowledge and it also deals with mean difference in pretest and, posttest and "t" value, thus the effectiveness of the study is found. The pretest mean difference is (13.81) and posttest mean difference is (26.03). The overall calculated' value (44.54, $p<0.05$) in knowledge aspect was greater than table value (0.75) at 0.05 level of significance. Hence it is concluded that there is very high significant gain in knowledge of anorexia nervosa.

H1: There is a significant difference between the mean pre- test and post - test knowledge of adolescent girls regarding anorexia nervosa.

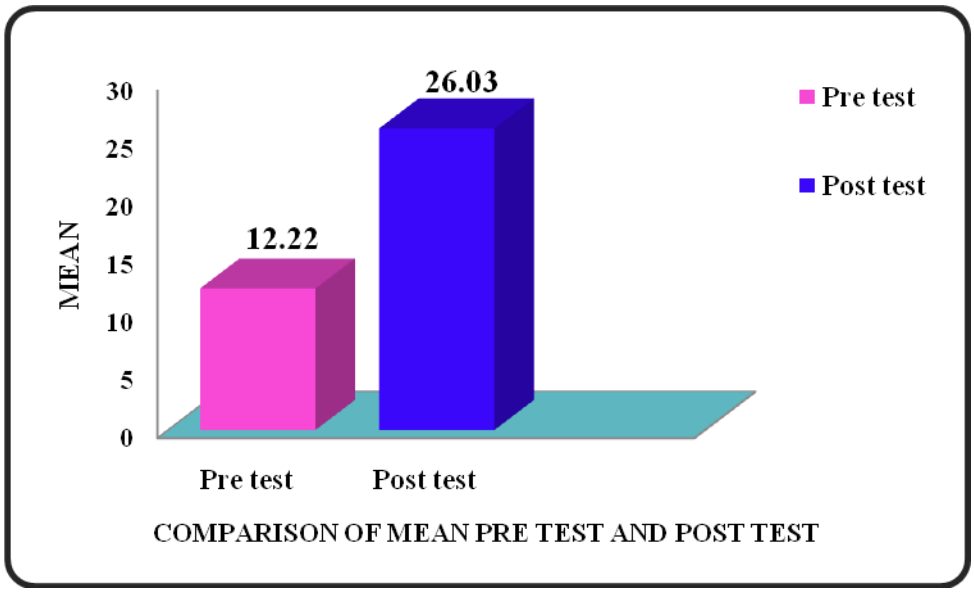


Figure 18: Comparison of mean pretest and posttest knowledge level of adolescent girls.

SECTION-IV

Association of pre- test level of knowledge of adolescent girls with selected demographic variables.

Table 4: Association of demographic variables with the pretest knowledge score.

S.I	Variables	<mean(12)	>mean(12)	X^2	Df	Level of significance
1	**Age**					
	17 -18	37	30	0.050	1	P>0.05 #
	18 - 19	19	14			**NS**
2	**Religion**					
	Hindu	40	51			
	Christian	1	3	4.18	2	P>0.05 #
	Muslim	0	5			**NS**
3	**Type of family**					
	Nuclear	23	34			
	Joint	17	18	9.41	2	P>0.05 * S
	Extended	1	7			
4	**Area of residence**					
	Urban	29	35			P>0.05 #
	Rural	10	17	0.836	2	**NS**
	Slum	3	6			
5	**Mother's education status**					
	Illiterate	3	5			
	High school	25	19	14.48	4	P>0.05 * S
	Higher secondary	8	24			

	Under graduate Post graduate	2 0	10 4			
6	**Father's Occupation** Unemployed Self – employee Private employee Government employee	 0 27 12 2	 0 43 9 7	3.68	3	P>0.05 # **NS**
7	**Monthly income** Below Rs. 5000 Rs.5001 – 10000 Rs.10001 – 15000 Above Rs. 15000	 15 20 3 2	 16 30 10 4	2.56	3	P>0.05 # **NS**
8	**Food pattern** Vegetarian Non- Vegetarian	 14 19	 19 40	0.041	1	P>0.05 # **NS**
9	**Type of food** Fatty meals Junk foods Balanced diet Normal diet	 11 9 3 12	 13 11 3 38	5.33	3	P>0.05 # **NS**
10	**No of meals pattern per day** 1 time meal per day 2 times meal per day 3 times meal per day More than 3 times/day	 15 11 08 06	 22 21 04 13	9.01	3	P>0.05 * S

11	**Source of previous** information Family members Friends Mass media No previous information	 03 02 03 40	 02 03 03 44	1.207	3	P>0.05 # **NS**
12	**Body Mass Index** Low weight Normal weight Over weight Obesity	 12 30 05 00	 13 35 03 02	2.614	3	P>0.05 # **NS**

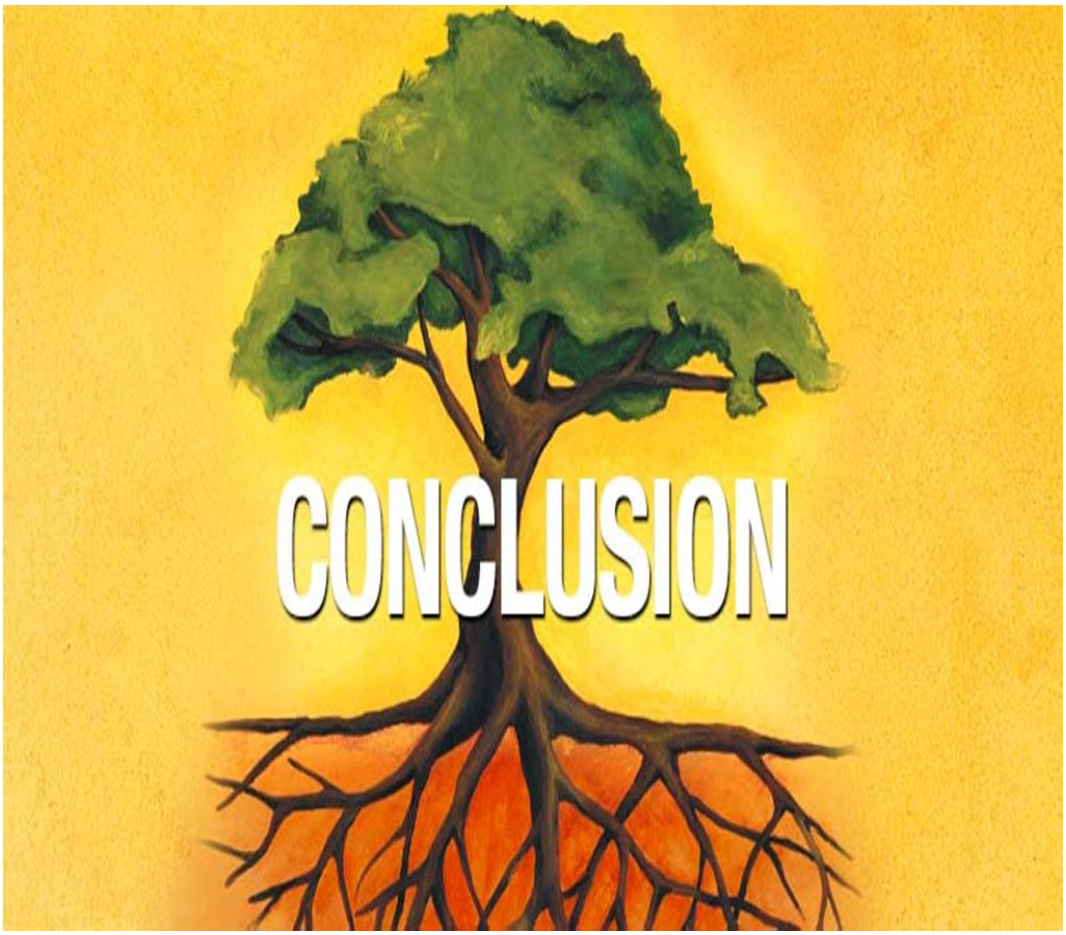
 # (NS) Not significant *** (S) Significant**

Table 4 data presented reveals that association between pre – test and demographic variables the calculated Chi- square values as used. The researcher has mentioned age of adolescent girls obtained chi- square value 0.050 at df 1 was not significant at 0.05 level. Religion of adolescent girls obtained chi- square value 4.18 at df 2 was not significant at 0.05 level. Type of family of adolescent girls obtained chi- square value 9.41 at df 2 was significant at 0.05. Area of residence an adolescent girls obtained chi- square value 0.836 at df 2 was not significant at 0.05 level. Mother's education status of an adolescent girls obtained chi- square value 14.48 at df 4 was significant at 0.05 level. Father's occupation of an adolescent girls obtained chi- square value 3.68 at df 3 was not significant at 0.05 level. Monthly family income of an adolescent girls obtained chi- square value 2.56 at df 3 was not significant at 0.05 level. Food pattern of an adolescent girls obtained chi- square value 0.041 at df 1 was not significant at 0.05 level. Type of Food of an adolescent girls obtained chi- square value 5.33 at df 3 was not significant at 0.05 level. Number of meals pattern of an adolescent girls obtained chi- square value 9.01 at df 3 was significant at 0.05

level. Source of previous information regarding anorexia nervosa among adolescent girls obtained chi- square value 1.207 at df 3 was not significant at 0.05 level. Body mass index of an adolescent girls obtained chi- square value 2.614 at df 3 was not significant at 0.05 level.

CHAPTER- V

DISCUSSION AND CONCLUSION



CHAPTER - V

DISCUSSION, SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

DISCUSSION

The aim of the study was to find out the effectiveness of structured teaching programme in improving the knowledge of adolescent girls regarding anorexia nervosa.

Respondent Characteristics are as follows,

The first objective was assess the pretest level of knowledge of adolescent girls regarding anorexia nervosa and selected demographic under study.

The major finding of this study was the majority 80(80%) of the adolescent girls had inadequate knowledge regarding anorexia nervosa, 20(20%) of them had moderate knowledge regarding anorexia nervosa, and 0% no one had adequate knowledge regarding anorexia nervosa in the pretest. The above findings summaries that majority of the samples are having inadequate knowledge.

Stein glass J, (2015) a study conducted to investigating, inadequate intake and preference for low- calorie foods are salient behavioral features of Anorexia nervosa This study aimed to develop a new paradigm for experimentally modeling maladaptive food choice in AN. Individuals with AN (n=22) and healthy controls (HC, n=20) participated in a computer based Food Choice Task, adopted for individuals with eating disorders. Participants first rated 43 food images (including high- fat & low- fat items) for Healthiness and Tastiness. The result is the anorexia nervosa group was less likely to choose high fat foods relative to HC, as evidenced both in multilevel logistic regression ($z = 2.59$, $p = .009$) and ANOVA ($F (1, 39$ anorexia nervosa) $= 7.80$, $p = .008$) analyses. Health ratings influenced choice significantly more in anorexia nervosa relative to HC ($z = 2.7$, $p= .006$). The findings suggest that the experience of tastiness changes overtime and may contribute to perpetuation of illness. By providing experimental quantitative measure of food restriction , this task opens the door to new experimental investigations into the cognitive, affective, and neural factors contributing to maladaptive food choices characteristics of AN.

The second objective to evaluate the effectiveness of structured teaching program on knowledge regarding on anorexia nervosa among adolescent girls

In case of post –test level of knowledge 96(96%) out of 100 were acquired adequate level of knowledge, 4(4%) were having moderate level of knowledge, and no one had inadequate level of knowledge. The obtained "t" value (44.54) was significant at 0.05 levels with the degree of freedom 99. This indicates that, there is a significant difference between pre –test and post-test level of knowledge scores among adolescent girls regarding anorexia nervosa. Hence H1 was accepted.

Isomaa R, (2011) a study conducted to investigating the prevalence, incidence and development of eating disorders and subclinical eating pathology. A study was conducted in Western Finland with 595 adolescents. A screening questionnaire followed by a semi structured interview was used to determine the prevalence, incidence and development of eating disorders. The lifetime prevalence rates for females age 18 were 2.6 % for anorexia nervosa (AN), 0.4% for bulimia nervosa (BN) ,7.7% for AN- NOS,1.3% for BN-NOS and 8.5 subclinical eating disorder. No prevalent case of DSM-IV eating disorders was found among the males. The incidence rate of eating disorder in adolescents age 15 - 18 was 1641 per 100 000 person per year.

The third objective was to find the association between the level of the knowledge scores before structured teaching program and selected demographic variables.

The major findings of this study were showed that there was a significant association between pre-test knowledge score with the selected demographic variables such as father's education status, type of family, mother's occupation, habit of eating pattern and course. Hence the calculated Chi-square value was compared with the table value which was higher than the table value. So, the result proven that there was an association between pre-test knowledge score with the selected demographic variables. To prevent the anorexia nervosa among adolescent girls with no slim beauty conscious and standardized, diversified measures should be adopted so that outcome of anorexia nervosa prevention work should be assessed more objectively and effectively.

Wick K, (2011), a study conducted to assessing the real world effectiveness of a German school based interventions for primary prevention of anorexia nervosa in pre-adolescent girls. Anorexia nervosa is notoriously difficult to treat, has high mortality rates and has a prevalence peak in 15- year old girls. Intervention involved 9 guided lessons with special posters and group discussions. A parallel controlled with pre- post measurements and a three month follow up was conducted in 92 Thuringian schools (n = 1553 girls) in 2007 and 2008. Primary outcomes were conspicuous eating behavior, body self- esteem, and AN - related knowledge. After the primary interventions provides an efficient and practical model to increase AN- related protection factors.

SUMMARY

This chapter deals with the summary of the study. The main aim of the study was to find the effectiveness of structured teaching programme regarding anorexia nervosa among adolescent girls in a selected Women's college.

The conceptual frame work used for this study was based on general system's theory. One group pre – test post – test design (O1 X O2) was adopted for the present study. Study consisted of 100 adolescent girls. Purposive sampling technique was used to select the samples in a Women's college at sivagangai.

Content validity tool was established by giving five experts. The reliability of the tool was tested by split – half method using Karl Pearson's correlation co efficient and it was fond to be reliable.

A pilot study was conducted on 10 adolescent girls in St. Fatima Michael Engineering College. No further changes were made in the tool after pilot study. The main study was conducted at Madurai Sivakasi Nadar's Pioneer Meenakshi Women's College at Sivagangai. Data were analyzed by using descriptive and inferential statistics. The hypotheses had been tested at 0.05 level of significance.

Major findings of the study:

The findings of the study revealed that knowledge of the adolescent girls were not adequate, majority 80% of them were had inadequate level of knowledge, 20% of them had moderate level of knowledge, and no one had adequate level of knowledge.

After administration of structured teaching programme, the knowledge level has improved among adolescent girls regarding anorexia nervosa, majority 96% of the adolescent girls had adequate level of knowledge, 4% of them had moderate level of knowledge and no one had inadequate level of knowledge in the post-test.

Comparisons of mean pre test and post test level of knowledge shows, the "t" value (44.54) was significant at 0.05 level with the degree of freedom 99. This indicates that, there is significant difference between pre test and post test level of knowledge regarding anorexia nervosa among adolescent girls. Hence H_1 was accepted. Father education status, type of family, mother occupation, habit of eating pattern and course of the student and in the pre test level of knowledge at 0.05 level. These demographic variables calculated Chi- square value was 14.45 at df (4), type of family chi-square value 9.41 at df (2), mother occupation chi-square value 14.45 at df (3) and habit of eating pattern Chi-square value 9.03 at df (3) and course of the student chi-square value 16.96 at df (1) respectively and it was significant at 0.05 level, So the H_2 was accepted.

The overall experience of conducting this study was satisfying one, as there was good co-operation from adolescent girls and college authority. The study was a new learning experience for the investigator. The result of the present study reveals that structured teaching programme could be used as an effective teaching strategy.

CONCLUSION

The study findings provide the statistical evidence which clearly indicate that Structured Teaching Programme has significant effect on the level of knowledge in adolescent girls.

IMPLICATIONS OF THE STUDY

Nursing Practice:

The nurses can play an important role in imparting preventive health care. Health education conducted by the nursing personnel in the college helps in imparting knowledge regarding prevention of anorexia nervosa among adolescent girls. Staff Nurses can also educate the adolescent girls who visit the outpatient department or inpatient department and also do screening programme regarding anorexia nervosa.

This education will help the adolescent girls to understand in – depth about anorexia nervosa measures. Thereby they can adopt healthy life style practices, which will help to prevent the disease.

Nursing Research:

Nurses being the major focus in the health care delivery system must take the initiative in conducting research on significant health care problem among the vulnerable groups in community, especially adolescent girls. The researcher will help to prevent mortality and morbidity caused by any preventable illness such as anorexia nervosa. Nurse researcher can conduct studies to determine the effectiveness of education in terms of anorexia nervosa. Most researchers can be done on prevention of innovative methods of teaching preparation of teaching effective teaching materials, focusing on interest, quality and cost effectiveness**.**

Nursing Administration:

Nurse administrators are responsible to identify the nature of the problem and organize programme related to health promotion to the target people. The study assists the nursing administrative authorities to initiate and carry out health education programme in health care settings.

Nurse administrator can also take the initiative in imparting health information through different effective methods. They have to support and encourage the nursing students to participate in health promotion activities. Individual and group teaching can be arranged for adolescent girls.

Nursing Education:

Nursing education should prepare effective future nurses. Active participation of student nurses in conducting educational programmes to provide information regarding diseases of the reproductive tract and hygienic measures. The nursing curriculum focuses more on the preventive aspect, the nurse must therefore, be prepared to identify the areas of knowledge deficit through the assessment of learning needs of adolescents.

Health information can be impaired through various methods like lecture,

incidental teaching, and mass media. Several educational strategies can be used to disseminate the health information like lecture, demonstration, flip chart, flash cards, and hand out etc. which would make it interesting and helps to gain adequate knowledge. Nurses have to involve themselves in the areas of health practices which help to lead a healthy life.

LIMITATATIONS OF THE STUDY:

1. The study was conducted only one group of 100 students in a selected Women's college at Sivagangai, hence generalization is limited to the population under study.
2. The study did not use a control group and there is threat to internal validity as the investigator had no control over the events that took place between the pre-test and post- test.
3. Extraneous variables such as exposure to mass media were beyond researcher's control.

RECOMMENDATIONS:

On the basis of the findings of the study, the following recommendations are made for the future research.

1. A similar study can be replicated on a larger sample with demographic characteristics.
2. A similar study can be replicated with broader content area on anorexia nervosa.
3. A similar study can be done different setting.
4. A comparative study can be conducted to determine the knowledge of different age groups on anorexia nervosa.
5. A comparative study can be conducted to assess the knowledge of urban and rural adolescent girls regarding anorexia nervosa.
6. Same study can be conducted by using different teaching modalities

REFERENCES

1. Ayoton,A.K&Horrobin,D.F.(2004),Rapid improvement of severe anorexia nervosa during treatment with ethyl-eicosapentaenoate and micro nutrients , European Psychiatry 19(5);317-315.
2. A. H. Grisp, L.K.G Hsu, (2002) Brittien Harding. A study of 102 female patient of eating disorder in (London). www. Pubmed.com.
3. Andres- perpina s, Lozano-serra.E. (2011), Clinical and biological correlation of adolescent anorexia nervosa. www. Pubmed.com.
4. Bimla kapoor (2004), Text book of Psychiatric Nursing, Kumar publishing house, New delhi. Page no: 187.
5. Basavanthappa BT,(2001) Nursing Research.(1 st edition), Jaypee brother's publishers, New delhi.
6. Buhrich N. (1981) Frequency presentation of anorexia nervosa Aust NJZ psychiatry. Page no: 153-155.
7. Fichter MD, Elton M, et al (1997) Structured interviews for anorexia nervosa, Int J Eating Discord, Page no: 468- 47.
8. Garner DM, Garfinkel PE. (2004), Socio cultural factors in the development of anorexia nervosa. Psychological medicine. Page no: 647-656.
9. Gower's S. Bryant & Waugh R(2004), Management of child and adolescent eating disorders, Journal of Child Psychology and Psychiatry and allied disciplines 45 (1); 63-83.
10. Han W hock (2005), The incidence of anorexia in Curacao. American journal of psychiatry. Page no: 748- 752.
11. Hotta M, et al (2009), Ghrelin increases hunger and food intake in patients with restricting type of anorexia nervosa, Endocrine Journal 56(9), 1119-28.
12. Hockenbury , Don and Hockenbury Sandra(2008) Psychology,Worth publishers, Newyork ISBN .

13. Jauregui Lobera I, Leon Lozano P.(2010) Traditional and new stratgies in the primary prevention of eating disorders in Spain.page no : 263- 272.

14. Dr.K.Lalitha. (2008) Mental Health and Psychiatric nursing. An Indian perspective, VMG publishers Banglore. page no: 480-485.

15. Ker linger N.F. (1973) Foundation of behavioral research (New York). Page no 29-30

16. Khandelwal SK, Saxene S.(1995) Eatin disorder An Indian Perspective. International Journal of Social Psychiatry. Page no : 132-146.

17. Kuboki P, Nomura S. (1996), Epidemiological data on anorexia nervosa in Japan. Psychiatry Research, University students. J Soc Psychol. Page no: 351-357.

18. Kim Y. R. et al. (2009) Childhood risk factors in korean women with anorexia nervosa. International journal of Eating disorder, Available from URL;http//www.pubmed.com.

19. Le Grange (2005) The Maudsley family – based treatment for adolescent anorexia nervosa, World psychiatry. Page no: 142- 146.

20. Lask B, (2002) Anorexia nervosa and related eating disorders in childhood and adolescence, psychology press. Page no : 804 – 846

21. Matthew Tiemeyer, (2007) Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Associtation (APA), page no:135-137.

22. Mamman P, Russell S. (2011) prevalence of Eating disorder & psychiatric co-morbidity among children and Adolescent in Tamil Nadu, India. www. pubmed.com

23. Mishera S.K, (2010) Eating disorder and weight concerns among Sikkim Adolescent girl in Kolkata, (India). 1 – 7 www. Pubmed .com.

24. Michelle Morrison (1997), Foundation of mental health nursing, (2 nd edition), USA.Mosby publishers, page no: 215

25. MC Anasrney ER, Zarcone J, Singh P,(2011) Restrictive anorexia and set shifting in Adolescence in Newyork, USA.Ersevier publishers.

26. Nakamura K, Yama moto M, (2000) Prevalence of anorexia nervosa and bulimia nervosa in a geographically define area in Japan. Internatioal Journal of Eating Disorders. page no: 173- 180.

27. Neinstein L, Juliani M (1996), Psychological development in normal adolescents, Williams and Wilkins publisher's, Page no 42- 44.

28. Neill O,(1982) Mental health nursing, (1 st edition). USA. Mosby puplisher, page no: 55.

29. Polit F Densie, Hungler P.Bernadette, (2004) "Nursing Research principal and method "(Philadelphia) 7th edition, J.B: Lippincott Company, page no: 1-5, 104-109, 194.

30. Pawluck DE, Gorey KM (1998), Seculer trends in the incidence of anorexia nervosa, page no: 347 – 352, pubmed.

31. Palazidou E,(1990) Neuro radiological and Neuropsychological assessment in anorexia nervosa, psychology medicine. Page no: 521- 527.

32. Rooney B. (1995) The prevalence of Anorexia nervosa South west London. Page no: 209-307.

33. Strober M, Freeman R,(1997), The long term course of severe anorexia nervosa in adolescents, Int J Eat Disord, page no: 334- 360, pubmed.

34. Treanure J, Russell G,(2010) A systemativity compile and Analysis the mortality rates in individual with anorexia nervosa and Bulimia nervosa.www.pubmed.com.

35. TNNMC, (2013) Journal of Mental Health Nursing, vol -I, Anorexia nervosa, Official publications of TNNMC, page no: 26.

36. The Journal of Nursing Times (2013, Jan), A positive nurse patient relationship is vital in anorexia nervosa treatment, vol; 109,No:33/34.

37. The Journal of Eating Disorders (Aug 2013), Assessment of Anorexia nervosa.

38. The Journal of Eating Disorders (2015), Telemedicine of family based treatment for adolescent anorexia nervosa, online publishers. Page3; 25.

39. The Journal of Eating Disorders (July 2015), Dysfunctional metacognition and drive for thinness in typical and atypical anorexia nervosa, online pu3;24.

40. The Journal of Eating Disorders (2015), Time to restore body weight in adults and adolescents receiving cognitive behaviour therapy for anorexia nervosa, 3;25.

41. Med Mc Grill Journal of Medicine (2007), The physiological consequences of starvation and the need for primary prevention efforts,10(7);20-25.

42. The American Journal of Psychiatry (2007),Treatment for anorexia nervosa,vol-164,online publishers.

43. The Journals Nursing Times (2013), Managing anorexia nervosa in the community, Vol; 109; 33/34, 12-14.

44. Ward A, Brown N, (1997), persistent osteopenia after recovery from anorexia nervosa. Int J Eat Disord, page no: 71 -75, pubmed.

45. Westenhoefer J (2001), prevalence of eating disorders and weight control practices in Germany in 1990 and 1997. Int J Eat Disorder, page no 477-481.

.

APPENDIX I

RESEARCH TOOL

SECTION A
SOCIO DEMOGRAPHIC DATA OF ADOLESCENT GIRLS

1) Age in years

a) 17 – 18 ( )

b) 18 – 19 ( )

2) Religion

a) Hindu ( )

b) Christian ( )

c) Muslim ( )

3) Type of family

a) Nuclear family ( )

b) Joint family ( )

c) Extended family ( )

4) Father's educational qualification

a) Illiterate ( )

b) High school ( )

c) Higher secondary ( )

d) Under Graduate ( )

e) Post Graduate ( )

5) Mother's educational qualification

a) Illiterate ( )

b) High school ( )

c) Higher secondary ( )

d) Under Graduate ( )

e) Post Graduate ( )

6) Father's occupation

a) Unemployed ( )

b) Coolie ( )

c) Private employee ( )

d) Government employee ( )

7) Mother's occupation

a) House wife ( )

b) Self employee ( )

c) Private employee ( )

d) Government employee ( )

8) Socio – Economic status of the family

a) Low class family ( )

b) Middle class family ( )

c) Upper class family ( )

9) Monthly income of the family

a) Below Rs. 5000 ( )

b) Rs .5001-10000 ( )

c) Rs.10001-15000 ( )

d) Above Rs. 15000 ( )

10) Area of residence

a) Rural ( )

b) Urban ( )

c) Slum ( )

11) Habit of food pattern

a) Vegetarian ( )

b) Non- Vegetarian ( )

12) Type of food Pattern

a) Fatty Meals ( )

b) Junk Foods ( )

c) Balanced diet ( )

d) Normal diet ( )

13) No of meals pattern per day

a) 1 time meals per day ( )

b) 2 time meals per day ( )

c) 3 time meals per day ( )

d) 4 time meals per day ( )

14) Previous source of information about Anorexia Nervosa?

a) Through mass media ( )

b) Through friends ( )

c) Family members ( )

d) No ( )

15) Physical measurement

Height in cm _____

Weight in m^2 _____

SECTION B

STRUCTURED KNOWLEDGE QUESTIONS ON ANOREXIA NERVOSA

1. Adolescent period refers to

a) 10 – 14 years

b) 15 – 19 years

c) 20 – 30 years

d) 30 years and above

2. Weight and body image are

a) Stable body measures

b) Unstable body measures

c) Dynamic body measures

d) Non variable body measures

3) Unhappy with their body structure and consider themselves to be fat even though their BMI are below normal in

a) Conduct disorder

b) Bulimia nervosa

c) Anorexia nervosa

d) Mood disorder

4) Which one is the high risk in eating disorder?

a) Anorexia nervosa

b) Bulimia nervosa

c) Pica eating

d) None of the above

5. What is anorexia nervosa?

a) Stuffing oneself with food

b) Refusal of eating due to fear of over weight

c) Trying to vomit to lose weight

d) Feeling of Emptiness in the stomach

6. Who are affected with Anorexia Nervosa more frequently?

a) Toddlers

b) Adolescents

c) Middle age groups

d) Old age group

7. Anorexia nervosa is highly affected in

a) Male

b) Female

c) Both

d) None of the above

8. Westernization, Industrialization, Modernization are the causes for

a) Developing anorexia nervosa

b) Developing bulimia nervosa

c) Developing self confidence

d) Developing personality

9. The causes which leads the adolescent girls to be a victim of anorexia nervosa

a) Family pressure among adolescent girls to be slim

b) Media and advertising images promoting thinner as ideal

c) Tendency in women's media to push weight loss program

d) All the above

10. Strict dieting increases the risk of developing

a) Conduct disorder

b) Tic disorder

c) Anorexia nervosa

d) Sexual disorder

11. Warning sign of Anorexia nervosa?

a) Rapid weight loss or frequent changes in weight

b) Frequent changes in height

c) Frequent changes in taste

d) Rapid weight gain

12. What are all the primary symptoms for Anorexia nervosa?

a) Resistance to maintaining body weight

b) Fear of weight gain

c) Irregular menstruation

d) All the above

13. Anorexic person consume

a) Less protein

b) Less calories

c) Less fat

d) Less vitamins

14. People with anorexia nervosa have a self esteem that is highly dependent on

a) Their character and attitude

b) Their body sizes and shape

c) Their willpower and ability

d) Their knowledge and personality

15. Distorted perception of self, being pre- occupied with food, refusing to eat, inability to remember things are

a) Psychological signs of bulimia nervosa

b) Psychological signs of anorexia nervosa

c) Psychological signs of pica eating

d) Psychological signs of binge eating

16. Two diagnostic tests that are often used in anorexia nervosa are

a) Eating attitude test and eating disorder

b) Personality test and aptitude test

b) Blood glucose test and urine test

d) Intelligence test and attitude test

17. BMI means

a) Body Mass Index

b) Body Measurement Index

c) Body Mass Identity

d) Body Movement Index

18. A person's BMI is a measurement that represents the relationship between

a) Weight and their Height

b) Height and their age

c) Weight and their age

d) Weight and their Image

19. The normal value of BMI is

a) Less than 18.5

b) 18.5 – 24.9

c) 25 – 30

d) More than 30

20. Which of the following is a risky eating behavior in an adolescent?

a) Eating junk foods all the time

b) Eating 3 times a day

c) Drinking plenty of water

d) Having a cup of milk a day

21. What is the optional choice therapy for anorexia nervosa?

a) Psycho therapy

b) Music therapy with dance

c) Aroma therapy

d) Occupational therapy

22. What is the drug of choice for Anorexia nervosa?

a) Anti depressants

b) Anti manic drugs

c) Anti epileptics

d) None of the above

23. To foster a healthy relationship with food, one has to

a) Try to label food as good or bad

b) Avoid using food as bribes or punishment

c) Do severe fasting

d) Do heavy exercises

24. Adolescent girls feel good about their body images when we

a) Demonstrate healthy eating and sensible exercises

b) Show an acceptance of different body shape and size

c) Do criticize or comment on them about their appearance

d) Answer a and b

25. Adolescent girls encourage to

a) Adapt healthy food habits

b) Skip the meals

c) Do exercises

d) Induce vomiting

26. What is behavior modification in Anorexia nervosa?

a) Efforts to change the psychological problems.

b) Efforts to change the physical problems

c) Efforts to change the maladaptive eating behaviors

d) Efforts to change the attitude of a person

27. The following is the complications of anorexia nervosa except

a) Malnutrition

b) Absence of menstruation

c) Poor concentration

d) Obesity

28. Which are all the system affected by anorexia nervosa?

a) Cardio Vascular system

b) Central nervous system

c) Gastrointestinal system

d) All the above

29. What is the aim of prevention of Anorexia nervosa?

a) Rule out medical complications of Anorexia nervosa

b) Treatment of Asthma

c) Supporting people with eating disorder

d) Treatment of eye disease

30. Why, the early detection of Anorexia nervosa not possible for most of the cases?

a) Maintaining body image

b) Interest to follow the mass media influence

c) Activity related impression

d) Societal attraction

வளர் இளம் பெண்கள் பற்றியசமூகபொதுப்புள்ளிவிபரப் பட்டியல்

பகுதி அ

1. வயது (ஆண்டுகளில்)

அ) 17 – 18 ( )

ஆ) 18 – 19 ( )

2..மதம்

அ) இந்து ( )

ஆ) கிறிஸ்தவம் ( )

இ) இஸ்லாம் (முஸ்லிம்)

3. குடும்பவகைப்பாடு

அ) தனிக் குடும்பம் ( )

ஆ) கூட்டுக் குடும்பம் ( )

இ) விரிவாக்கப்பட்டகுடும்பம் ( )

4. வாழும் பகுதி

அ) கிராமம்புறம் ( )

ஆ) நகர்புறம் ( )

இ) குடிசைப் புறம் ( )

5. தாயின் கல்வித் தகுதி

அ) படிப்பறிவின்மை ( )

ஆ) உயர்நிலைக் கல்வி ( )

இ) மேல் நிலைக் கல்வி ( )

ஈ) இளம் பட்டதாரி ( )

உ) முதுகலைப்பட்டதாரி ( )

6. தந்தையின் தொழில்

அ) வேலையின்மை ( )

ஆ) கூலித் தொழில் ( )

இ) தனியார் வேலை ( )

ஈ) அரசாங்கவேலை ( )

7. குடும்பமாதவருமானம்

அ) ரூ5000-த்திற்குக் கீழ் ( )

ஆ) ரூ 5001 – 10000 ( )

இ) ரூ 10001 – 15000 ( )

ஈ) ரூ 15000 க்குமேல் ( )

8. உணவுப்பழக்கவழக்கங்கள்

அ) சைவம் ( )

ஆ) அசைவம் ( )

9. உணவின் வகைப்பாடு

அ) கொழுப்புச் சத்துள்ளஉணவு ( )

ஆ) மதிப்பற்றஉணவு ( )

இ) சரிவிகிதஉணவு ( )

ஈ) சாதாரணஉணவு ( )

10. ஒருநாளைக்குரியஉணவின் எண்ணிக்கை

அ) ஒருநாளைக்குஒருமுறை ( )

ஆ) ஒருநாளைக்கு இரு முறை ( )

இ) ஒருநாளைக்கு மூன்றுமுறை ( )

ஈ) ஒருநாளைக்குநான்குமுறை ( )

11. பசியிழப்புநோயினைப் பற்றியமுந்தையதகவல் கிடைக்கப் பெற்ற வழி?

அ) மக்கள் தொடர்புஅமைப்புவாயிலாக ( )

ஆ) நண்பர்களின் வாயிலாக ( )

இ) குடும்பஉறுப்பினர்கள் வாயிலாக ( )

ஈ) எதுவுமில்லை ( )

12. உடலின் அளவு

அ) உயரம் (செ.மீ) ( )

ஆ) எடை (மீ2) ( )

பகுதி ஆ

பசியிழப்புநோயினைப் பற்றியஅறிவினைக் சோதித்தறியும் உருவமைக்கப்பட்டவினாத்தாள்

1. வளர் இளம் பருவத்தினர் என்பது

   அ) 10 – 14 வயது

   ஆ) 15 – 19 வயது

   இ) 20 – 30 வயது

   ஈ) 30 வயதுமற்றும் அதற்குமேல்

2. எடைமற்றும் உடல் தோற்றம் என்பது

   அ) நிலையானஉடல் அளவு

   ஆ) நிலையற்றஉடல் அளவு

   இ) மாறுபட்க் கூடியஉடல் அளவு

   ஈ) வேறுபடாதஉடல் அளவு

3. உடல் அமைப்பில் சந்தோசமின்மைமற்றும் உடல் தசைகுறியீடுகுறைவாக இருந்தபோதும் குண்டாகதன்மைப்பற்றிஏற்றுக்கொள்வது

   அ) நடத்தைக் குறைபாடு

   ஆ) இயற்கைமீறியபெரும்பசி

   இ) பசியிழப்புநோய்

   ஈ) மனபோக்கில் குறைப்பாடு

4. அதிகஅபாயகரமானஉணவூட்டக் குறைபாட்டில் ஒன்றுஎது?

   அ) பசியிழப்புநோய்

   ஆ) இயற்கைமீறியபெரும் பசி

   இ) பல்பம் மண் போன்றவற்றைஉண்பது(சத்துகுறைந்தபொருட்களைஉண்பது

   ஈ) மேலுள்ளவற்றில் எதுவும் கிடையாது

5. பசியிழப்புநோய் என்றால் என்ன?

அ) ஒருவருக்குஉணவினைத் திணிப்பது

ஆ) உடல் எடைஅதிகரிக்கும் என்றபயம் காரணமாக

உணவினைத் தவிர்பது

இ) உடல் எடையைக் குறைக்கஉண்டஉணவினைவாந்திஎடுப்பது

ஈ) வயிறுகாலியாக இருப்பதாகஉணர்வது

6. பசியிழப்புநோயினால் தொடர்ந்துபாதிக்கப்படுபவர்கள் யார்?

அ) சிறுகுழந்தைகள்

ஆ) வளர் இளம் பருவத்தினர்

இ) நடுத்தரவயதினர்

ஈ) முதியவர்கள்

7. பசியிழப்புநோயினால் அதிகமாகப் பாதிக்கப்பட்டுள்ளவர்கள்

அ) ஆண்கள்

ஆ) பெண்கள்

இ) இருபாலரும்

ஈ) மேலேகண்டயாரும் கிடையாது

8. மேற்கத்தியகலாச்சாரம்,தொழில் மேம்பாடு,நாகரீகம் போன்றவை உருவாக்கியதுயாது?

அ) பசியிழப்புநோய் உருவாதல்

ஆ) இயற்கைமீறியபெரும்பசிநோய் உருவாதல்

இ) தன்னம்பிக்கைஅதிகரித்தல்

ஈ) வெளிப்புறத்தோற்றம் அதிகரித்தல்

9. வளர் இளம் பருவததினரை பசியிழப்பு நோயாளியாக உருவாக்கும் காரணங்கள் யாவை?

அ) வளர் இளம் பருவத்தினரிடையேஒல்லியானஉருவகத்தைஏற்படுத்தும்

ஆ) மெல்லியஉருவஅமைப்பினைசிறந்ததாகசித்தரிக்கும் குடும்ப

அழுத்தநிலை

இ) பெண்கள் உடல் எடையைக் குறைக்கும் விளம்பரத்துறையின் தோற்றம் நிகழ்ச்சிக்குதள்ளும் பெண்கள் பற்றியசெய்திவிளம்பரம்

ஈ) மேல் கண்டஅனைத்தும்

10. கடுமையானஉணவுக் கட்டுப்பாடுஉருவாக்கும் அபாயம் எது?

அ) நடத்தைக் குறைபாடு

ஆ) முகத்தின் தசைகள் தானே இழுததுக் கொள்ளும் குறைபாடு

இ) பசியிழப்புநோய்

ஈ) பாலுணர்வுக் குறைபாடு

11. பசியிழப்புநோய்க்கானஅபாயக் குறியீடுகள் யாவை?

அ) வேகமானஉடல் எடைகுறைவுஅல்லதுதொடர்ந்துமாறுபடும் எடை

ஆ) தொடர்ந்துமாறுபடும் உயரம்

இ) தொடர்ந்துமாறுபடும் சுவை

ஈ) வேகமாகஎடைஅதிகரிப்பு

12. பசியிழப்புமுதன்மைஅறிகுறிகள் என்ன?

அ) உடல் எடைகொள்வதற்கானஎதிர்ப்புச் செயல்

ஆ) உடல் எடைஅதிகரிப்பில் பயம்

இ) ஒழுங்கற்றமாதவிடாய்

ஈ) மேற்கண்டஅனைத்தும்

13. பசியிழப்புநோயாளிஉண்பதுயாது?

அ) குறைந்தபுரதம்

ஆ) குறைந்தகலோரி

இ) குறைந்தகொழுப்பு

ஈ) குறைந்தஉயிர்ச்சத்து

14. பசியிழப்புநோயாளிதன்னைத் தானேபெருமையாகநினைத்துக் கொள்ளும் செயல் எதனைச் சார்ந்தது?

அ) அவர்களுடையநடத்தைமற்றும் எண்ணங்கள்

ஆ) அவர்களுடையஉடல் அளவுமற்றும் அமைப்பு

இ) அவர்களுடையமனசக்திமற்றும் செயல்

ஈ) அவர்களுடையஅறிவுநிலைமற்றும் வெளித் தோற்றம் நிலை

15. தன்னைப் பற்றிஅறிவதில் குறைபாடு,உணவுபற்றியமுன் சிந்தனை,உணவைத் தவிர்ப்பதுமற்றும் பொருட்களைஞாபகம் கொள்ளமுடியாமைபோன்றஅறிகுறிகள் யாவை?

அ) இயற்கைமீறியபெரும்பசியின் மனநிலைக் குறியீடு

ஆ) பசியிழப்புநோயின் மனநிலைக் குறியீடு

இ) சத்துகுறைந்தபொருட்களைஉண்பதற்கானமனநிலைக் குறியீடு

ஈ) அளவுக்குமீறிஉண்பதின் மனநிலைக் குறைபாடு

16. பசியிழப்புநோய்க்குபொதுவாகஉபயோகப்படும் இரண்டுபரிசோதனைமுறைகள் யாவை?

அ) உணவுபற்றியஎண்ணஒட்டசோதனைமற்றும் உணவூட்டக் குறைப்பாடு

ஆ) உடல் வெளித் தோற்றம் மற்றும் நுண்ணறிவுத்திறன் சோதனை

இ) இரத்தசர்க்கரைமற்றும் சிறுநீர்ப் பரிசோதனை

ஈ) அறிவுமற்றும் எண்ணஒட்டப் பரிசோதனை

17. உடல் எடைக் குறியீட்டின்அர்த்தம்யாது?

அ) உடல் தசைக் குறியீடு

ஆ) உடல் அளவீடுக் குறியீடு

இ) உடல் தசைகண்டறிதல்

ஈ) உடல் அசைவுகுறியீடு

18. ஒருமனிதனுடையஉடல் எடைக்குறியீடு எதற்குரிய தொடர்பைப் பிரதிபலிக்கின்றது?

அ) உடல் எடைமற்றம் உயரம்

ஆ) வயதுமற்றும் உயரத்திற்குமானதொடர்பு

இ) எடைமற்றும் உயரத்திற்கானதொடர்பு

ஈ) எடைமற்றும் உடல் தோற்றம்

19. உடல் எடைக் குறியீட்டின் சரியானமதிப்பீடுஎவ்வளவு?

அ) 18.5 க்கும் குறைவு

ஆ) 18.5 – 24.9

இ) 25 – 30

ஈ) 30 க்குமேல்

20. வளர் இளம் பருவத்தினருக்கானஅபாயகரமானஉணவூட்டப் பழக்கவழக்கம் என்ன?

அ) சத்தற்றஉணவுகளைஅனைத்துவேளையும் அருந்தவது

ஆ) மூன்றுவேளைமட்டும் உண்பது

இ) தண்ணீர் மட்டும் அதிகம் பருகுவது

ஈ) ஒருவேளைப் பால் மட்டும் அருந்துவது

21. பசியிழப்புநோயிற்கானதேர்ந்தெடுக்கப்பட்டசிகிச்சையாது?

அ) மனச்சோர்விற்கானமாத்திரைகளுடன் மனநலச் சிகிச்சை

ஆ) நடனத்துடன் கூடிய இசைச் சிகிச்சை

இ) நறுமனதிரவியச் சிகிச்சை

ஈ) தொழிற் சார்ந்தசிகிச்சை

22. பசியிழப்புநோய்க்கானதேர்ந்தெடுக்கப்பட்டமாத்திரைஎது?

அ) மனச் சோர்விற்குஎதிரானமாத்திரைகள்

ஆ) அதிக இன்பத்தைக் குறைக்கும் மாத்திரைகள்

இ) வலிப்புநோய்க்கானமாத்திரைகள்

ஈ) மேலேகண்டஎதுவும் கிடையாது

23. உணவூட்டத்தின் நலமானபினைப்பைஏற்படுத்த

அ) உணவினைநல்லது,தீயதுஎனமுத்திரைஒட்டவேண்டும்

ஆ) உணவினைஏமாற்றுவதற்கும்,தண்டனைக்குரியபொருளாகவும் உபயோகிக்கக் கூடாது

இ) கடினமானவிரதத்தைக் கடைப்பிடிக்கவேண்டும்

ஈ) திவிரஉடற்பயிற்சிமேற்கொள்ளவேண்டும்

24. வளர் இளம் பெண்கள் அவர்களின் உடல் தோற்றத்தினைநல்லவிதமாகஉணருகிறார்கள் எப்பொழுதுதென்றால்

அ) நலமானஉணவூட்டம் மற்றும் உணர்வுப்பூர்வமானஉடற்பயிற்களைச் செய்யும் பொழுது

ஆ) வெவ்வேறுவிதமானஉடல் அமைப்புமற்றும் தோற்றத்தினைஏற்றுக் கொள்ளும் பொழுது

இ) அவர்களுடையதோற்றத்தைப் பற்றிஅவர்களேகருத்துதெரிவிக்கும் பொழுது

ஈ) விடை (அ) மற்றும் (ஆ) சேர்ந்து

25. வளர் இளம் பெண்கள் ஊக்குவிக்கப்படுகிறார்கள் எதற்கென்றால்

அ) நலமானஉணவூட்டத்தைஏற்றுக்கொள்வதற்கு

ஆ) உணவைத் தவிர்ப்பதற்கு

இ) அதிகஉடற்பயிற்சிசெய்வதற்கு

ஈ) வாந்தியைஏற்படுத்துவதற்கு

26. பசியிழப்புநோயில் பழக்கவழக்கங்களைமாற்றம் செய்தல் என்றால் என்ன?

அ) மனநலப் பிரச்சனைகளைத் தவிர்ப்பதற்குமுயற்சிஎடுப்பது

ஆ) உடல் நலப்பிரச்சனைகளைமாற்றுவதற்குமுயற்சிஎடுப்பது

இ) ஏற்றுக்கொள்ளப்படதாஉணவுப்பழக்கவழக்கங்களைமாற்றுவதற்குமுயற்சிஎடுப்பது

ஈ) ஒருதனிநபரின் எண்ணத்தைமாற்றமுயற்சிஎடுப்பது

27. கீழ்வருவனவற்றில் ஒன்றைத்தவிரமற்றவைகள் பசியிழப்புநோயின் பின்விளைவுகள் ஆகும் அதுயாது?

அ) உணவூட்டக் குறைபாடு

ஆ) மாதவிடாய் ஏற்படாதிருத்தல்

இ) கவனமின்மை

ஈ) உடல் பருமன்

28. பசியிழப்புநோயினால் எந்தஉடல் அமைப்புகள் பாதிக்கப்படுகின்றன?

அ) இருதயமண்டலம்

ஆ) நரம்புமண்டலம்

இ) உணவுமண்டலம் (சீரணமண்டலம்)

ஈ) மேற்கண்டஅனைத்தும்

29. பசியிழப்புநோயினைத் தடுப்பதற்கானநோக்கம் என்ன?

அ) பசியிழப்புநோயினால் வரும் மருந்துவப் பின் விளைவுகளைஆராய்வதற்கு

ஆ) மூச்சிரைப்புநோய்க்குசிகிச்சைஅளிப்பதற்கு

இ) உணவூட்டகுறைபாட்டினால் பாதிக்கப்பட்டவர்களுக்குஆதரவுஅளித்தல்

ஈ) கண் நோய்க்குசிகிச்சைஅளிப்பது.

30. பசியிழப்புநோயினால் பாதிக்கப்பட்டவர்களைஆரம்பநிலையிலேயேஏன் கண்டறியமுடியவில்லை?

அ) உடல் தோற்றத்தைநிலைநிறுத்துவதால்

ஆ) செய்திமற்றும் விளம்பரத்தின் ஆதிக்கத்தைதொடர்வதற்குவிருப்பம் கொள்வதால்

இ) வேலைதொடர்பானநன் மதிப்பினைஏற்படுத்துவதால்

ஈ) சமூகத்தினரைஈர்ப்பதனால்

APPENDIX - IV

ANSWER KEY

Answer key and score for the structured teaching knowledge questionnaire to assess the knowledge regarding anorexia nervosa.

SL.NO	ANSWER KEY	SCORE
1	b	1
2	a	1
3	c	1
4	a	1
5	b	1
6	b	1
7	b	1
8	a	1
9	d	1
10	c	1
11	a	1
12	d	1
13	b	1
14	b	1
15	b	1
16	a	1
17	a	1
18	a	1
19	b	1
20	a	1
21	a	1
22	a	1
23	a	1
24	d	1
25	a	1
26	c	1
27	d	1
28	d	1
29	a	1
30	d	1

APPENDIX - V

LESSON PLAN

ON

ANOREXIA NERVOSA

Regno : 301331551

II YrM.Sc (N)

RASS ACADEMY COLLEGE OF NURSING, POOVANTHI

As a part of dissertation submitted to

THE TAMILNADU DR. M.G.R MEDICAL UNIVERSITY, CHENNAI.

TOPIC	:	ANOREXIA NERVOSA
GROUP	:	ADOLESCENT GIRLS
PLACE	:	SELECTED COLLEGE
DURATION		45 MINUTES
METHOD OF TEACHING		LECTURE CUM DISCUSSION
PREVIOUS KNOWLEDGE	:	BASIC KNOWLEDGE REGARDING ANOREXIA NERVOSA AMONG ADOLESCENT GIRL'S
TEACHING AIDS	:	LCD

General Objectives;

At the end of the teaching adolescent girls will acquire adequate knowledge regarding Anorexia nervosa.

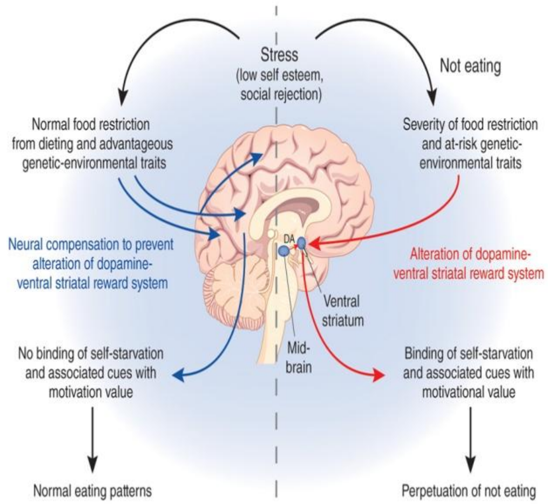
Specific objectives:

At the end of the sessions the students will be able to,

- Describe the definition of Anorexia nervosa
- Explain the incidence rate of Anorexia nervosa
- Describe the causes of Anorexia nervosa
- Enumerate the Pathophysiology of Anorexia nervosa
- Point out typical manifestations of Anorexia nervosa
- Explain the treatmentfor Anorexia nervosa
- Explain the complications of anorexia nervosa
- List down the preventive measures of Anorexia nervosa.

TIME	SPECIFIC OBJECTIVES		TEACHING LEARNING ACTIVITIES	AUDIO VISUAL AIDS	EVALUATION
1mt	Introducing the topic	**INTRODUCTION;** Adolescence is a transitional stage of physical and psychological human development generally occurring during the period from puberty to teenage (15- 19yrs of age) eating behaviors and they may start skipping meals or possibly under eating or over eating.	Teacher introduce the topic	LCD	
2mts	Describe the definition	**DEFINITION ;** Anorexia nervosa is characterized by refusal to maintain a healthy body weight, a fear of gaining weight and an unrealistic perception of current body weight.	Teacher: define the anorexia nervosa Learner: active listening.		Define anorexia nervosa?
2mts	Explain the incidence rate of anorexia nervosa	**INCIDENCE ;** Anorexia has the highest mortality rate among all psychological disorders. ➢ Approximately 90 -95 % of Anorexia nervosa suffers are girls and women.(American Psychiatric Association , 1994) ➢ Between 0.5 – 1 % American women suffer from Anorexia nervosa. ➢ Between 5 -20 % of individuals struggling with	Teacher: Explain the incident rate of anorexia. Learner: active listening	LCD	Explain the incident rate of anorexia nervosa

3 min	List out the causes and risk factors for anorexia nervosa	Anorexia will die. ➢ Mainly seen in adolescent period ➢ It occurs in the age group of 13 -21 years. **CAUSES :** • Family and social pressure • Westernization • Modernization • Industrialization • Crash dieting • Media and advertising images promoting thinner as ideal. **RISK FACTORS:** • Strict dieting • Body dissatisfaction • Perfectionism • Family history of eating disorders • History of physical or sexual abuse • Low self esteem.	Teacher: describe the causes and risk factors for anorexia nervosa Learner: active listening	LCD	List down the causes and risk factors for anorexia nervosa?

3 min	Enumerate the patho-physiology of anorexia nervosa	**PATHOPHYSIOLOGY ;**  	Teacher: Enumerate the pathophysiology Learner: active listening	LCD	Explain the patho physiology of anorexia nervosa?
5 min	Pointing out the signs and symptoms of anorexia nervosa	**Signs and symptoms of anorexia** Living with anorexia means you're constantly hiding your habits. This makes it hard at first for friends and family to spot the warning signs. When confronted, you might try to explain away your disordered eating and wave away concerns. But as anorexia progresses, people close to you won't be able to deny their instincts that something is wrong—and neither should you. As anorexia develops, you become increasingly preoccupied with the number on the scale, how you look in the mirror, and	Teacher: Pointing out the signs and symptoms of anorexia nervosa Learner: taking	LCD	List out the signs and symptoms of anorexia nervosa?

		what you can and can't eat. **Anorexic food behavior signs and symptoms** • **Dieting despite being thin** – Following a severely restricted diet. Eating only certain low-calorie foods. Banning "bad" foods such as carbohydrates and fats. • **Obsession with calories, fat grams, and nutrition** – Reading food labels, measuring and weighing portions, keeping a food diary, reading diet books. • **Pretending to eat or lying about eating** – Hiding, playing with, or throwing away food to avoid eating. Making excuses to get out of meals ("I had a huge lunch" or "My stomach isn't feeling good."). • **Preoccupation with food** – Constantly thinking about food. Cooking for others, collecting recipes, reading food magazines, or making meal plans while eating very little. • **Strange or secretive food rituals** – Refusing to eat around others or in public places. Eating in rigid, ritualistic ways (e.g. cutting food "just so", chewing food and spitting it out, using a specific plate).	notes.		

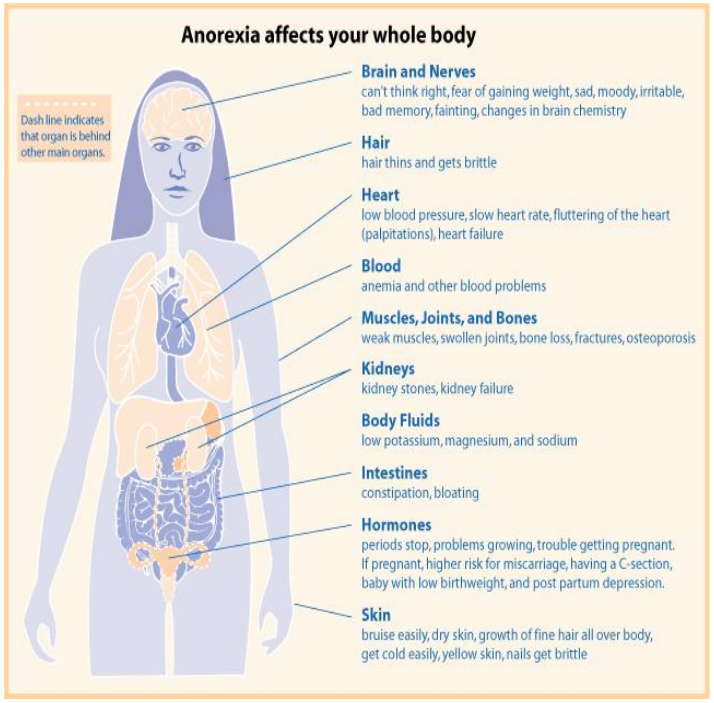
		Anorexic appearance and body image signs and symptoms • **Dramatic weight loss** – Rapid, drastic weight loss with no medical cause. • **Feeling fat, despite being underweight** – You may feel overweight in general or just "too fat" in certain places such as the stomach, hips, or thighs. • **Fixation on body image** – Obsessed with weight, body shape, or clothing size. Frequent weigh-ins and concern over tiny fluctuations in weight. • **Harshly critical of appearance** – Spending a lot of time in front of the mirror checking for flaws. There's always something to criticize. You're never thin enough. • **Denial that you're too thin** – You may deny that your low body weight is a problem, while trying to conceal it (drinking a lot of water before being weighed, wearing baggy or oversized clothes). **Purging signs and symptoms** • **Using diet pills, laxatives, or diuretics** – Abusing water pills, herbal appetite suppressants, prescription		LCD	

2 min	Explain the diagnostic evaluation for anorexia nervosa	stimulants, ipecac syrup, and other drugs for weight loss. • **Throwing up after eating** – Frequently disappearing after meals or going to the bathroom. May run the water to disguise sounds of vomiting or reappear smelling like mouthwash or mints. • **Compulsive exercising** – Following a punishing exercise regimen aimed at burning calories. Exercising through injuries, illness, and bad weather. Working out extra hard after bingeing or eating something "bad." **DIAGNOSTIC GUIDELINES FOR ANOREXIA NERVOSA ;** As per ICD -10 , F .50 .0 ➢ Body weight is maintained at least 15 %below that expected body mass index is 18.5 or less. Quetelets Body mass index =weight (kg) height (m)2 Used for age 16 or above. Two diagnostic tests are often used to identify anorexia	Teacher: explain the diagnostic evaluation for anorexia nervosa.	LCD	Explain the diagnostic guidelines for anorexia nervosa?

4 min	Explain the treatment modalities for anorexia nervosa	nervosa. ➢ Eating attitude test ➢ Eating disorder inventory **SCOFF** questionnaire, developed in Great Britain, is sometimes used when anorexia nervosa is suspected. A "yes" response to at least two of the following questions is an amongindicator of an eating disorder. **S: "**Do you feel sick because you feel full?" C: "Do you lose control over how much you eat?" O: "Have you lost more than 13 pounds recently?" F: "Do you believe that you are fat when others say that you are thin?" F: "Does food and thoughts of food dominate your life?" **TREATMENT MODALITIES FOR ANOREXIA NERVOSA ;** In this treatment , many type of strategies are there **1) Effective communication strategies** **2) Milieu Therapy** **3) Cognitive behavior therapy** **4)Behavior and Interpersonal therapies** **5) Individual psychotherapy**	Teacher: explain the treatment measures for anorexia nervosa. Learner; active	LCD	Explain the treatment modalities for anorexia nervosa?

		6) Family therapy **7) Group therapy** **8) Pharmacological treatment.** **1)EFFECTIVE COMMUNICATION STRATEGIES ;** ❖ Develop a rapport with client. ❖ Create non – threatening and non – punitive environment. ❖ Put the client at ease while communicating. ❖ Maintain professional boundaries. **2) MILIEU THERAPY ;** ❖ The client is given a designed amount of time to complete meals. ❖ Unit activities closely supervised. **3)COGNITIVE BEHAVIOR THERAPY ;** ❖ Cognitive behavior approaches, are aimed at reducing symptoms and restructuring the belief system that perpetuates the illness. ❖ To identify at risk periods as well as to self – monitor eating patterns. **4)BEHAVIOR AND INTERPERSONAL THERAPIES ;** In addition to cognitive behavior therapy approaches include behavior therapy and interpersonal therapy.	listening.		

		5)INDIVIDUAL PSYCHOTHERAPY ; Individual psychotherapy is generally included treatment protocols. It is helpful in assisting the client to establish more realistic thinking process. ➢ Increase self esteem. ➢ Establish healthy self control. ➢ Express emotions and needs more directly. **6)FAMILY THERAPY ;** Family therapy includes education of each family member about anorexia nervosa and signs &symptoms, treatment and preventive measures. **7)GROUP THERAPY ;** This therapy may helps the client in a more pleasing way as the client can see others with the same problems. What she is facing (as in self help groups) and the client feels more liberal when she is in a group of familiar people. **8)PHARMACOLOGICAL MANAGEMENT ;** There are no specifically indicated medications for anorexia nervosa. Anti -depressants medication may be considered, but depressive symptoms may be consequences of malnutrition that will reunite upon weight restoration.			

5 min	List down the complications of anorexia nervosa	**COMPLICATIONS ;** Anorexia nervosa are associated with serious complications,  **Problems in Cardio vascular system ;** ➢ Poor circulation ➢ Irregular heart beats ➢ Hypotension ➢ Heart valve disease –Mitral valve prolapsed	Teacher; list out the complications of anorexia nervosa. Learner; active listening.	LCD	List out the complications for anorexia nervosa?

		➢ Heart failure ➢ Edema on the leg and face ➢ ECG abnormalities ➢ Myocarditis **Problems with bones and muscles ;** ➢ Muscle weakness ➢ Fragile bones (osteoporosis) ➢ Problems with physical development in children & young adults. **Dermatologic problems ;** ➢ Brittle hair and nails ➢ Hair loss ➢ Dry skin ➢ Lanugos **Endocrine Problems ;** ➢ Hypo glycemia ➢ Cold intolerance ➢ Amenorrhea **Fluid and electrolyte problems ;** ➢ Dehydration ➢ Alkalosis (vomiting) ➢ Acidosis			

		Sexual problems; ➢ Irregular menstruation &Infertility in women ➢ Loss of sexual interest & erectile dysfunction in men. **Problems with Central Nervous system ;** ➢ Seizures ➢ Difficulties with concentration & memory ➢ Irritability **Hematologic complications;** ➢ Anemia ➢ Leucopenia **Gastro intestinal complications;** ➢ Decrease intestinal mobility ➢ Constipation ➢ Bloating **Other problems;** ➢ Kidney damage ➢ Liver damage **Pregnancy Complications;** ➢ Miscarriage ➢ Premature birth babies ➢ Low birth weight baby			

3 min	Explain the preventive measures	**Dental problems;** ➢ Enamel erosion These are the complications for Anorexia nervosa. **PREVENTIVE MEASURES;** **<u>AIM;</u>** ➢ To rule out the medical complications**.** ✓ Early identification of changes in body weight. ✓ Primary reinforcement of taking healthy And nutritive foods. ✓ Foster a healthy relationship with food ✓ To label food as good or bad. ✓ Show an acceptance of different body shape and size. ✓ Encourage to adopt healthy food habits ✓ Counseling. ✓ Allowing the adolescent girls more opportunities for depth and intimate discussions on issues such as body image and self esteem. ✓ Awareness of the disorders and how to prevent them & how to notice them early and how to seek help should be done. ✓ Provide adolescents discussions about school, family,	Teacher; explain the preventive measures. Learner; active listening.		Explain the preventive measures for anorexia nervosa?

		nutrition and extracurricular activities & problems. ✓ Effective communication is also essential in primary prevention. **PREVENTION AND INTERVENTION AT COLLEGE LEVEL;** ➢ Create a college environment where all students feel safe from harassment. ➢ Focus physical education on skills building and establishing healthy eating habits, not weight management. ➢ Ensure that participation in college or co-curricular activities is not limited by a student's body size or shape. ➢ Provide general information about information about Anorexia nervosa and let students know where they can get help. **CONCLUSION;** At the end of the teaching, adolescent girls gain adequate knowledge regarding Anorexia nervosa and also give assurance not to follow such activities of intake of foods.			

பசியிழப்பு நோய்

(மனப்பாதிப்பால் பசியின்மை, நரம்புத் தளர்ச்சிப் பசியின்மை)

பற்றிய பாட திட்டம்

பகுதி	:	பசியிழப்பு நோய்
குழு	:	வளர் இளம் பெண்கள்
இடம்	:	தேர்வு செய்யப்பட்ட கல்லூரி
கால அளவு	:	45 நிமிடங்கள்
பயிற்றுவிக்கும் முறை	:	உரையாடல் மற்றும் கலந்து ஆலோசித்தல்
முற்தைய பாட அறிவு	:	வளர் இனம் பெண்களிடையே பசியிழப்பு நோய் பற்றிய அடிப்படை அறிவு.
பயிற்றுவிக்க உதவும்		
பொருள்கள்	:	நீர்மப் படிக ஒளித்திரை (LCD)

பொதுவான குறிக்கோள்:

பசியிழப்பு நோய் பற்றிய பயிற்றுவிப்பின் முடிவில் வளர் இனம் பெண்கள் அந்நோயினைப் பற்றிறய போதுமான அறிவினைப் பெறுதல்.

முக்கிய குறிக்கோள்கள்:

புசியிழப்பு நோயினைப் பற்றிய நிகழ்ச்சியின் முடிவில் மாணவர்கள் விவரிக்க வேண்டியவை.

- பசியிழப்பு நோயினைப் பற்றிய விளக்கம்.
- பசியிழப்பு நோயினால் புதிதாகப் பாதிக்கப்பட்டவர்களின் எண்ணிக்கையை தெரிவித்தல்.
- பசியிழப்பு நோயினால் ஏற்படும் உடற் கூறுச் செயல் மாற்றங்களை வரிசைப்படுத்துதல்.
- பசியிழப்பு நோயினால் ஏற்படும் அறிகுறிகளை குறிப்புரைத்தல்.
- பசியிழப்பு நோய்க்கான சிகிச்சை முறைகளை விவரித்தல்.
- புசியிழப்பு நோயினால் ஏற்படும் விளைவுகளை விவரித்தல்.
- பசியிழப்பு நோய்க்கான தடுப்பு முறைகளை வரிசைப்படுத்துதல்.

காலம்	முக்கிய குறிக்கோள்கள்	உள்ளடக்கம்	பயிற்றுநர் /பயில்வோர் செயல்பாடுகள்	பயிற்று விக்க உபயோகிக்கப் படும் பொருள்	மதிப்பீடு
1நிமிடம்	பாட அறிமுகம்	**முன்னுரை:** வளர் இனம் பருவமானது உடல் மற்றும் மனநிலைகளில் வளர்ச்சி ஏற்படுவது ஆகும். பொதுவாக பூப்படைதலில் இருந்து இளம் வயது வரை ஏற்படும் பொதுவான வளர்சிச நிலை (15-19 வயது வரை) ஆகும். வுளர் இனம் பருவத்தினர் என்பது 13-18 என்ற வயது நிலையில் உள்ளவர் ஆவர். இவ்வயது நிலையில்தான் வளர் இளம் பருவத்தினர் குழந்தை என்ற நிலையிலிருந்து இளைய வயதினர் என்ற நிலையை அடைகின்றனர். இவ்வயது நிலைக்கு ஏற்றவாறு வளர் இளம்பருவத்தினர் உடல் வளர்ச்சி, பாலின உணர்வு மற்றும் மன வளர்ச்சி அடைகின்றனர். இவ்வயது நிலையில் உணவூட்டம் என்பது அவர்களுடைய உடல்வளர்ச்சி மற்றம் மனவளர்ச்சிக்கு ஏற்றவாறு இருப்பது மிகவும் முக்கியமானதாகக் கருதப்படுகின்றது.	பாட அறிமுகம்		
2 நிமிடங்கள்	வரையறை விளக்குதல்	**வரையரை** வளர் இளம்பருவத்தினர் சில குறிப்பிட்ட காரணங்களினால் உணவு உண்ணும் கால வேளைகளைத் தவிர்தது குறை ஊட்டம் அல்லது மிகை உணவூட்டம் என்ற நிலைக்குச் செல்கின்றனர்.	பயிற்றுனர் விளக்குதல் பயில்வோர் கவனித்தல்	நீர்மப் படிக ஒளித்திரை	பசியிழப்பு நோயினைப் பற்றிய விளக்குக

2 நிமிடங்கள்	பசியிழப்பு நோயினால் பாதிக்ககப்பட்டவர்களின் எண்ணிக்கையை தெரிவித்தல்	**பாதிப்படைபவர் எண்ணிக்கை (விகிதம்):** பசியிழப்பு நோயானது மனநிலைக் குறைபாடுகளில் அதிக அளவு இறப்பு எண்ணிக்கையைக் கொண்டுள்ளது. • சாதாரணமாக 90-95%சிறுமிகள் மற்றும் பெண்கள் பசியிழப்பு நோயினால் பாதிக்கப் படுகின்றனர்.(அமெரிக்கள் சைக்கியாட்டிரிக் அசோசியேசன், 1994). • 5-20 % விசிதர்சசாரத்திற்கு இடையில் உட்ளள தனிநபர் பசியிழப்பு நோயினால் சிரமப்பட்டு உயிரிழக்கின்றார். • வுளர் இளம் பருத்தினரிடையே பசியிழப்பு நோயினை முக்கியமாகப் பார்க்க முடிகின்றது. • 13-21 வயது வந்தோருக்கு இந்நோய் ஏற்படுகின்றது.	பயிற்றுனர் பாதிக்கப்பட்டவர்களின் எண்ணிக்கைய விளக்குதல் பயில்வோர் கவனித்தல்	நீர்மப் படிக ஒளித்திரை	பசியிழப்பு நோயினால் பாதிக்கப்பட்டவர்களின் எண்ணிக்கையை விளக்குக?
	பசியிழப்பு நோயின் காரணங்கள் மற்றும் அபாய காரணிகளை வரிசைப்படுத்துதல்	**காரணங்கள்:** பசியிழப்பு நோயின் காரணம் மற்றும் அபாயக் காரணிகளை வரிசைப் படுத்துதல். • குடும்ப மற்றும் சமூக அழுத்த நிலைமை. • மேற்கத்தியக் கலாச்சாரம். • நாகரீகத்தின் விளைவு	பயில்வோர் கவனித்தல்		பசியிழப்பு நோயின் காரணங்களை வரிசைப்படுத்துக

3 நிமிடங்கள்	பசியிழப்பு நோயினால் ஏற்படும் உடற் கூறுச்செயல் மாற்றங்களை வரிசைப்படுத்துதல்	• தொழில் மேம்பாட்டின் விளைவு. • நொறுக்குத் தீனி • மெல்லிய உருவ அமைப்பினைச் சிறந்ததாக்ச சித்தரிக்கும் செய்தி மற்றும் விளம்பரத்தின் தோற்றம். **அபாயக் காரணிகள்:** • கடுமையான உணவுக் கட்டுப்பாடு • உடல் நிறைவடையாக நிலை • பூரணத்துவம் • குடும்ப உறுப்பினர்கயிடையே உணவூட்டக் குறைபாடு. • தன்னைப் பற்றித் தானே குறைத்து மதிப்பிடுதல்.	பயிற்றுனர் விளக்குதல் பயில்வோர் கவனித்தல்		பசியிழப்பு நோயினால் ஏற்படும் உடற் கூறுச்செயல் மாற்றங்களை வரிசைப்படுத்துக .

3 நிமிடங்கள்	பசியிழப்பு நோயினால் ஏற்படும் தானறிகுறிகளை குறிப்பிடுதல்	**பசியிழப்பு நோயினால் ஏற்படும் உடற்கூறு மாற்றங்கள்:** மன அழுத்தம் (தன்னைப் பற்றித் தானேகுறைவாக மதிப்பிடுதல்சமூகத்திலிருந்து விலகுதல்) ↓ தீவிர உணவுக் கட்டுப்பாடுமற்றும் அபயாகரமான மரபணு சூழ்நிலைக் குணாதிசயம் ↓ டோபமின்-வெண்ட்ரள் தெளி மதிப்பு அமைப்பில் ஏற்படும் மாறுபாடு தானே பட்டினி கிடத்தலமற்றும் ஊக்க மதிப்பு மற்றும் குறிகளில் கூட்டுச்சேர்ந்து இருத்தல் ↓ உணவு உண்ணாது இருக்கும் நிலைக்கு ஆட்படுதல். ↓ அபாயகரமான உடற்கூறு மாற்றங்கள் ஏற்படுதல்.	பயிற்றுனர்: பசியிழப்பு நோயின் அறிகுறிகள் மற்றும் குறியீடுகளைக் குறிப்பிடுதல்பயிற்றுநனர்:குறிப்பு எடுத்தல்	நீர்மப் படிக ஒளித்திரை	

5 நிமிடங்கள்		**பசியிழப்பு நோயினால் ஏற்படும் அறிகுறிகள்:** • உணவுக் குறைபாட்டுப் பழக்கவழக்கங்களை தொடர்நது மறைப்பது. • பசியிழப்பு நோயிற்கான அபாயக் குறியீடுகளை நண்பர்கள் மற்றும் குடும்ப உறுப்பினர்களால் சுட்டிக் காட்ட முடியாத கடினத்தை ஏற்படுத்துகின்றது. • ஆனால் பசியிழப்பு நோய் தொடரும் பட்சத்தில் நோயாளியோ அல்லது அவருக்கு மிகவும் நெருக்கமாணவாக்ள நோயினால் ஏற்படும் விபரீதத்தை அறிந்து கொள்ள முடியும். • பசியிழப்பு நோய் உருவாகும் பொழுது, நோயாளி தான் எப்படி கண்ணாடியில் பிரதிபலிக்கின்றோம் என்றும், தன்னால் என்ன செய்ய முடியும் மற்றும் சாப்பிட முடியாத நிலை, அளவுகோலில் உள்ள எண்கள் எனப் பலவாறு ஆட்கொள்ளப் படுகிறார்கள். **பசியிழப்பு நோய் உணவுப் பழக்க வழக்க குறியீடு மற்றும் அறிகுறிகள்:** **உடல் மெலிதலுக்கான உணவுப் பழக்கம்:** கடினமான உணவுக் கட்டுப்பாட்டைக் கடைப்பிடித்தல். குறைவான கலோரி உணவுகளை மட்டும் உட்கொள்ளுதல்.			பசியிழப்பு நோயினால் ஏற்படும் குறியீடு மற்றும் அறிகுறிகளை வரிசைப்படுத்துக.

	பசியிழப்பு நோயினைக்	மாவுச்சத்து மற்றும் கொழுப்பு உணவினை கெடுதல் உணவுகளாகக் கருதி உண்ணாமல் தடை செய்வது. **கலோரிகள், கொழுப்புச்சத்து மற்றும் உணவூட்டத்தில் பிடிவாதம்:** • உணவுச் சீட்டுகளை வாசித்து கலோரி குறைவான உணவினை உண்ணுதல், • உணவினைப் பகுதியாகப்பிரித்து அளந்து, எடை போட்டு மிகவும் குறைவாக உண்ணுதல், • உணவுக் குறிப்பேடுகளை வைத்துக் கொண்டு அதன்படி மட்டும் உணவு உண்ணுதல் **உணவு உண்பது போன்று பாவனை மற்றும் உணவு உண்பதில் பொய்மை:** • உணவு உண்ணாமையை மறைத்தல், உணவை உண்ணாமல் விளையாடுதல் மற்றும் உணவைத் தவிர்ப்பதற்காக உணவினை எறிதல் போன்றவை. **உணவினைப் பற்றிய எண்ணங்களில் ஆட்படுதல்:** உணவைப் பற்றிய தொடர் சிந்தனை. மற்றவர்களுக்குகாக உணவு சமைப்பது, சமையல்குறிப்புகளைச் சேகரித்தல், உணவு பற்றிய ஏடுகளை வாசித்தல், அல்லது தயாரித்து அதன் மூலமே உணவு			

2 நிமிடங்கள்	கண்டறியும் மதிப்பீட்டு முறைகளை விளக்குதல்	உண்ணும் முறையைக் கையாளுவது. **விசித்திரமான மற்றும் ரகசியமான உணவு பற்றிய சடங்குகள்:** • பொது இடங்கள் மற்றும் மக்கள் சுற்றியுள்ள இடங்களில் உணவு உண்பதைத் தவிர்ப்பது. • சுடங்கு முறைகள்:(எ.கா: உணவினை விலக்குவது (உணவின் முக்கியத்துவம் அறியாமல் அதனை பொருட்படுத்தாமல் விலக்குவது, உணவினை மென்று தின்று அதனைத் துப்புவது, உணவு உண்பதற்கு தனித்துவமான தட்டுகளை உபயோகிப்பது) **பசியிழப்பு நோயின் தோற்றம் மற்றும் உடல் அமைப்பின் குறியீடு மற்றும் அறிகுறிகள்:** (தானறிகுறிகள்) • பகிரங்கமாக எடை குறைதல்: . • உடல் எடை மிகவும் குறைவாக இருக்கும்பொழுது மிகவும் குண்டாக இருப்பது போன்ற உணர்வு: • உடல் தோற்றத்தினைப் பற்றிய தீர்வு: • உடல் எடைக் குறைப்பில் தவறு உள்ள பகுதியைச் சோதனைச் செய்தல்: • பசியிழப்பு நோயினால் பீடிக்கப்பட்டவர் தான் மெலிந்த உடல் அமைப்பினை பெற்றதை ஏற்றுக் கொள்ளாமை.	பயிற்றுனர்: பசியிழப்பு நோயினைக் கண்டறியும் மதிப்பீட்டு முறைகளை விளக்குதல். பயில்வோர் கவனித்தல்	நீர்மப்படிக ஒளித்திரை	பசியிழப்பு நோயினைக் கண்டறியும் மதிப்பீட்டு முறையினை விளக்குக.

	பசியிழப்பு நோயிற்கான சிகிச்சை முறைகளை விளக்குதல்.	**மலம் கழித்தலை ஏற்படுத்தும் குறியீடுகள் மற்றும் அறிகுறிகள்:** உணவூட்ட மாத்திரைகள், மலமிளக்கிகள் மற்றும் நீரோக்கும் மாத்திரைகளை உபயோகித்தல்: **உணவு உண்டபின் அதனை வீசி எறிவது:** உணவு உண்டபின் தொடர்ந்து மறைவது அல்லது கழிப்பறைக்குச் செல்லுதல். வாந்தி எடுக்கும் சத்தத்தை உணராமல் இருக்க குழாயில் நீரைத் திறந்து அதன் சத்தத்தை அதிகப்படுத்துதல் மற்றும் வாய்ச் சுத்தம் திரவம் மற்றும் புதினா போன்ற மணமூட்டும் பொருட்களை உபயோகித்து வாந்தியினால் ஏற்படும் துர்நாற்றத்தை வரவிடாமல் செய்வது. **பசியிழப்பு நோயினைக் கண்டறியும் வழிமுறைகள்:** ஐ.சி.டி.. 10, எப் 50.0 ன் படி., உடல் எடைக்குறியீடு 18.5 அல்லது அதற்குச் சிறிது குறைவான எடையை பெறுவதற்குப் பதிலாக 15 சதவீதத்திற்குக் குறைவான உடல் எடையைப் பெற்றிருத்தல் குவாட்டி பிளெட் உடல் எடைக் குறியீடு விகிதம்: எடை (கிகி) ---------- உயரம் (மீ)2 16 வயது (அ) அதற்கு அதிக வயதினருக்கு இந்த குறியீட்டு விகிதத்தைப் பயன் படுத்தி உடல் எடை மதிப்பீடு செய்யப் படுகின்றது.	பயிற்றுனர்: பசியிழப்பு நோயிற்கான சிகிச்சை முறைகளை விளக்குதல்		

4 நிமிடங்கள்		பசியிழப்பு நோயினைக் கண்டறிய இரண்டு விதமான சோதனை முறை உபயோகப்படுத்தப்படுகின்றது. அவையாவன. • உணவூட்ட எண்ணத்தை அறியும் பரிசோதனை • உணவூட்ட குறைபாட்டைக் கண்டறியும் கணக்கீடு. **ஸ்காப் வினாவிடை முறை:** இம்முறை கிரேட் பிரிட்டனில் உருவாக்கப்பட்டது. புசியிழப்பு நோயின் அறிகுறிகளை உணரும்பொழுது அதனைக் கண்டறிய இவ் வினாவிடை முறை உபயோகப்படுத்தப்படுகின்றது. கீழே வவரிக்கப்பட்ட வினாக்களில் இரண்டு வினாக்களின் விடைகள் “ ஆம்” என்ற பதில் அமைவதாகப் பெறின் அந்நபர் பசியிழப்பு நோயினால் பீடிக்கப்பட்டுள்ள நிலையைக் குறிக்கும். **ஸ்காப் (Scoff):** S- நீங்கள் உணவு உட்கொள்ளா நிலையை அடைய அதிக அளவு நீர் அருந்துவதால் நீங்கள் நோய் பீடிக்கப்பட்டதாகக் கருதுகிறீர்களா? c- நீங்கள் உணவு அருந்துவதில் உள்ள கட்டுப் பாட்டினை இழந்து விட்டீர்களா? o- நீங்கள் சமீபகாலமாக 13 பவுண்ட் உடல் எடையை இழந்து உள்ளீர்களா? f- நீங்கள் மற்றவர்கள் உங்களை மெலிந்த நிலையில் உள்ளீர்கள்	பயில்வோர்: கவனித்தல்.		பசியிழப்பு நோயிற்கான சிகிச்சை முறைகளை விளக்குக.

		என்று சொல்லும் பொழுது நீங்கள் உடல் எடை கூடியுள்ளதாக நம்புகிறீர்களா? f- உணவு மற்றும் உணவைப் பற்றிய எண்ணங்கள் உங்கள் வாழ்க்கையில் ஆக்கிரமிப்புச் செய்கின்றதா? **பசியிழப்பு நோயிற்கான சிகிச்சை முறைகள்:** இச்சிகிச்சையில் பலவகையான முறைகள் உள்ளன. ஆவையாவன 1. சிறப்பான தொடர்பு முறைகள் 2. மில்லியூ சிகிச்சை 3. அறிவுசார்ந்த பழக்க சிகிச்சை 4. பழக்க வழக்கம் சார்ந்த மற்றும் உள் மனது சார்ந்த சிகிச்சை 5. தனிமனித (தனிநபர்) மனநலச் சிகிச்சை. 6. குடும்ப உறுப்பினர்களுடன் கூடிய சிகிச்சை 7. குழச்சிகிச்சை 8. மருந்தக சிகிச்சை 1. **சிறப்பான தொடர்பு முறைகள்:** • நோயினால் பாதிக்கப் பட்டவரிடம் பிணைப்பு ஏற்படுத்தல். • பயமில்லாத மற்றும் தண்டனையில்லாத சூழ்நிலையை உருவாக்குதல் 2. **பாதுகாப்பான சூழ்நிலை சிகிச்சை:**	.		

5 நிமிடங்கள்	பசியிழப்பு நோயினால் ஏற்படும் விளைவுகளை வரிசைப்படுத்தல	• நோயினால் பாதிக்கப் பட்டவர் உணவு உண்டு முடிப்பதற்கு ஒரு குறிப்பிட்ட கால அளவை நிர்ணயிக்க வேண்டும். • நோயாளியின் குழு செயல் முறைகளை நெருக்கமாகக் கண்காணிக்க வேண்டும் 3. **அறிவு சாந்த பழக்க சிகிச்சை:** • அறிவு சார்ந்த பழக்க சிகிச்சையின் முக்கிய நோக்கமானது நோயாளியின் நோய் அறிகுறிகளைக் குறைப்பது மற்றும் அவர்களின் தன்னம்பிக்கை அமைப்பை மறு வழவம் ஏற்படுத்தி நோயின் தீவிர நிலைமையினைக் கட்டுக்குள் கொண்டு வருவதாகும். 4. **பழக்க வழக்கம் மற்றும் உள்மனது சார்ந்த சிகிச்சை:** • இச்சிகிச்சை முறையானது அறிவு சாந்த பழக்க வழக்க சிகிச்சை முறையுடன் சேர்ந்து செய்யக்கூடிய சிகிச்சை முறையாகும். 5. **தனிநபர் மனநலச்சிகிச்சை:** • தனிநபர் மனநலச்சிகிச்சை சிகிச்சை நெறமுறைகளை உள்ளடக்கியது. இது நோயாளிக்கு உண்மையான எண்ணம் மற்றும் செயல் முறைகளை உருவாக்க உதவிபுரிகின்றது. ஆவையாவன. • நோயாளி தன்னைப் பற்றி உயர்வாக நினைக்கும் எண்ணத்தை அதிகரிக்கின்றது.	பயிற்றுனர்: பசியிழப்பு நோயினால் ஏற்படும் விளைவுகளை வரிசைப்படுத்துதல். பயிலுனர்: கவனித்தல்		பசியிழப்பு நோயினால் ஏற்படும் விளைவுகளை வரிசைப்படுத்துக.

		6. குடும்ப உறுப்பினர்களுடன் கூடிய சிகிச்சை: • குடும்ப உறுப்பினர்களுடன் கூடிய சிகிச்சையானது குடும்ப உறுப்பினர்களுக்கு பசியிழப்பு நோயின் குறியீடுகள், அறிகுறிகள், சிகிச்சை மற்றும் தடுப்பு முறைகள் பற்றிய கல்வியை உள்ளடக்கியது. **7. குழுச்சிகிச்சை:** இக் குழுச் சிகிச்சையில் இந்நோயினால் பாதிக்கப் பட்டவாக்ள குழுவில் இடம் பெறுவர். எனவே நோயினால் பாதிக்கப்பட்ட ஒரு நோயாளி அதே நோயினால் பாதிக்கப்பட்ட மற்ற நோயாளியைப் பார்க்கும் பொழுது அவர்களுடைய நோயின் பிரச்சனைகளை சுலபமாக அறிந்து கொள்ள இக்குழுச் சிகிச்சை உதவி செய்கின்றது. **8. மருந்துச் சிகிச்சை:** பசியிழப்பு நோய் சிகிச்சைக்கு எந்த விதமான சிறப்பு மருந்துகளும் கிடையாது. மனச்சோர்வு மருந்துகள் இந்நோயினால் ஏற்படும் மனச் சோர்வைக் குறைக்க ஏற்றுக் கொள்ளலாம். **விளைவுகள்:** பசியிழப்பு நோய் தீவர விளைவுகளை உள்ளடக்கியது. பசியிழப்பு உடல் முழுவதையும் பாதிக்கின்றது. **மூளை மற்றும் நரம்புகள்:** சரியாக சிந்திக்க முடியாது,ஏடை கூடிவிடும் என்ற பயம், கவலை, சோர்வு, எரிச்சல் நிலை, ஞாபக மறதி, மயக்கம், மூளை,		நீர்மப்படிக	

3 நிமிடங்கள்	பசியிழப்பு நோயினைத் தடுக்கும் முறையினை விளக்குதல்	வேதிப் பொருட்களின் மாற்றம். **ரோமம்:** மெல்லிய, உடைந்து விடும் ரோமம், **இருதயம்:** குறைந்த இரத்த அழுத்தம், குறைவான நாடித்துடிப்பு, இதய படபடப்பு, இருதய செயலிழப்பு **இரத்தம்:** இரத்தசோகை மற்றும் இரத்தம் சம்பந்தப்பட்ட பிரச்சனை. **தசைகள் மூட்டுகள் மற்றும் எலும்புகள் தளர்ந்த தசைகள்:** தளர்ந்த தசைகள்,வீங்கிய மூட்டுகள்,எலும்பு இழப்பு, எலும்பு முறிவு,எலும்பு வலுயிழத்தல், **சிறுநீரகங்கள்:** சிறு நீரகக் கற்கள்,சிறு நீரகச் செயலிழப்பு **குடல்கள்:** முலச் சிக்கல்,வயிறு உப்பிசம் **ஹார்மோன்கள்:** **(வேதிவினை ஊக்கிகள்)** மாதவிடாய் நிறுத்தம்,வளர்ச்சியில் பிரச்சனை,கர்ப்பமடைவதில் சிக்கல்,கர்ப்பமடைந்தாலும் கருத் தங்காத நிலை, **சருமம்: (தோல்)** சுலபமாக இரத்தம் கண்ணிப் போதல், உலர்ந்த சருமம், உடல் முழுவதும் ரோமம் வளருதல், சுலபமாக மூக்கில் நீர் வழிதல். **நாளமில்லாச் சுரப்பிகளில் ஏற்பட்ட பிரச்சனைகள் :**	பயிற்றுனர்: பசியிழப்பு நோயினைத் தடுக்கும் முறையினை விளக்குதல். பயிலுனர்: கவனித்தல்.	ஒளித்திரை	பசியிழப்பு நோயினைத் தடுக்கும் முறையினை விளக்குக.

		குறைந்த இரத்தச் சர்க்கரை,குளிர் தாங்க முடியாத நிலைமாதவிடாய் ஏற்படாதிருத்தல் **நீர் மற்றும் உப்புகளில் ஏற்படும் பிரச்சனைகள்:** நீர்ச்சத்தின்மை,உடலில் காரத்தன்மை ஏற்றம் (வாந்தி), உடலில் அமிலத்தன்மை ஏற்றம் **பாலுணர்வு பிரச்சனைகள்:** ஒழுங்கற்ற மாதவிடாய் மற்றும் குழந்தையின்மை (பெண்களுக்கு),பாலுணர்வில் விருப்பமின்மை மற்றும் ஆண்களுக்கான பாலுறுப்புக் கோளாறு (ஆண்குறி செயலிழப்பு) **நரம்பு மண்டலப்பிரச்சனைகள்:** வலிப்பு நோய்,ஞாபகமறதி மற்றும் ஞாபக சக்தியில் பிரச்சனைகள், எரிச்சல் நிலைமை **பல் பிரச்சனைகள்:** பல் எனாமல் சிதைவு **பசியிழப்பு நோயினைத் தடுக்கும் முறைகள்:** **கொள்கைகள்:** மருந்துவ பின் விளைவுகளை ஆராயவேண்டும் • உடல் எடையில் ஏற்படும் மாற்றங்களை ஆரம்ப நிலையில் கண்டறிதல் • சத்து மற்றும் உடல் நலத்திற்குத்தேவையான உணவினை ஆரம்பத்திலே எடுத்துக் கொள்ள ஊக்குவிக்க வேண்டும் • உணவுடன் ஒரு நலமான பிணைப்பினை ஏற்படுத்த			

		வேண்டும் • உணவினை நல்லது அல்லது கெட்டது என்று மதிப்பிட வேண்டும் • மாறுபட்ட உடல் அமைப்பு மற்றும் தோற்றத்தினை ஏற்றுக் கொண்டதாகக் காண்பிக்க வேண்டும் • நலமான உணவுப் பழக்க வழக்கங்களுக்கு உட்பட்ட ஊக்குவிக்க வேண்டும். உணவு பற்றி ஆற்றுப்படுத்துதல் செய்ய வேண்டும். • வளர் இளம் பெண'களுக்கு உடல் தோற்றம் மற்றும் தன்னைத்தானே பெருமையாக நினைத்தல் போன்ற விஷயங்களில் ஆழமாகவும் மற்றும் வந்து தலான கலந்துரையாடல்களை செய்வதற்கான வாய்ப்புக்களை அளிக்க வேண்டும். • நோய்க் குறைப்பாடு பற்றிய விழிப்புணர்வு மற்றும் அக்குறைபாடுகளை விரைவாக அறிந்து மருத்துவ உதவியை நாடுவதற்கான வழி செய்ய வேண்டும். **கல்லூரி அளவில் பசியிழப்புநோய் தடுப்பு மற்றும் தீர்வு முறைகள்:** கல்லூரியின் அனைத்து மாணவர்களும் பாதுகாப்பாக உணரும் படியான கல்லூரி சூழ்நிலையை உருவாக்க வேண்டும் மாணவர்களின் திறமை வளர்ப்பதற்கான உடல் நலக் கல்வியை கவனம் செலுத்த வேண்டும். மேலும் நலமான உணவுப்			

		பழக்க வழக்கங்கள் மற்றும் எடை மேம்பாடு போன்றவற்றை உருவாக்க வேண்டும். பசியிழப்பு நோயினைப் பற்றிய பொதுவான தகவல்களைக் கல்லூரி மாணவர்களுக்கு வழங்க வேண்டும் மற்றும் அவாகள் எங்கு சென்று உதவி பெற வேண்டும் என்பதையும் அறிந்து கொள்ள வேண்டும். **முடிவுரை:** இப்பாட முடிவில் வளர் இளம் பெண்கள் பசியிழப்பு நோயினைப் பற்றிய முழுமையான அறிவினைப் பெற்றுள்ளார்கள் என்றும் அவாகள் எந்த விதமான உணவு உண்ணும் செயல் முறைகளில் மாற்றங்கள் செய்ய வில்லை என உறுதி அளிக்கின்றோம். .			

STRUCTURED TEACHING PROGRAMME ON ANOREXIA NERVOSA

Guided By
Mrs. Ruthrani, MSc (N)
HOD of psychiatric department
RASS Academy college of Nursing
Poovanthi

Prepared By

Reg.No. 301331551

INTRODUCTION

- Adolescence is a transitional stage of physical & psychological human development occurring during the period from puberty to adulthood, due to peer pressure they avoid eating foods.

DEFINITION

- **ANOREXIA NERVOSA;**

  It’s refers to refusal to maintain a healthy body weight , a fear of weight gaining, and an unrealistic perception of current body weight.

INCIDENCE

- 90-95% 0f Anorexia nervosa suffers are Girl's& women

Between 0.5-1% American women suffers Anorexia nervosa.

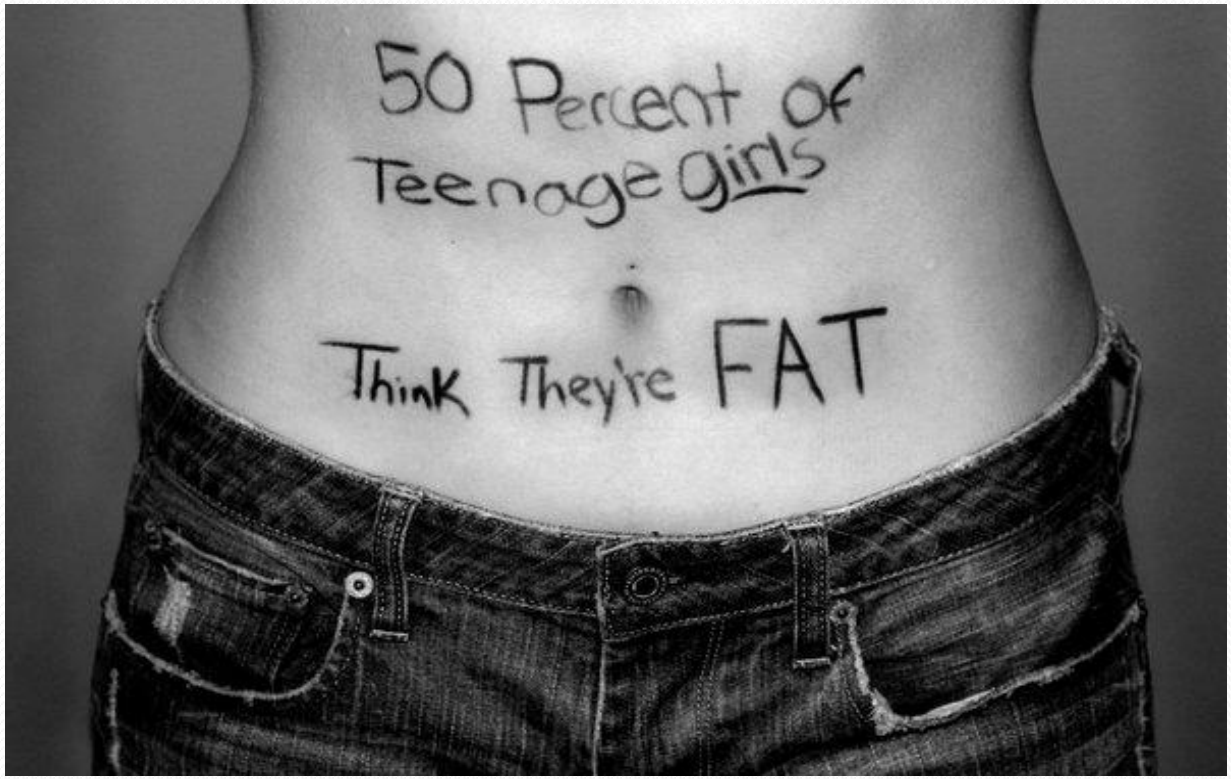
It's the high risk eating disorder cause serious issues.

RISK FACTORS

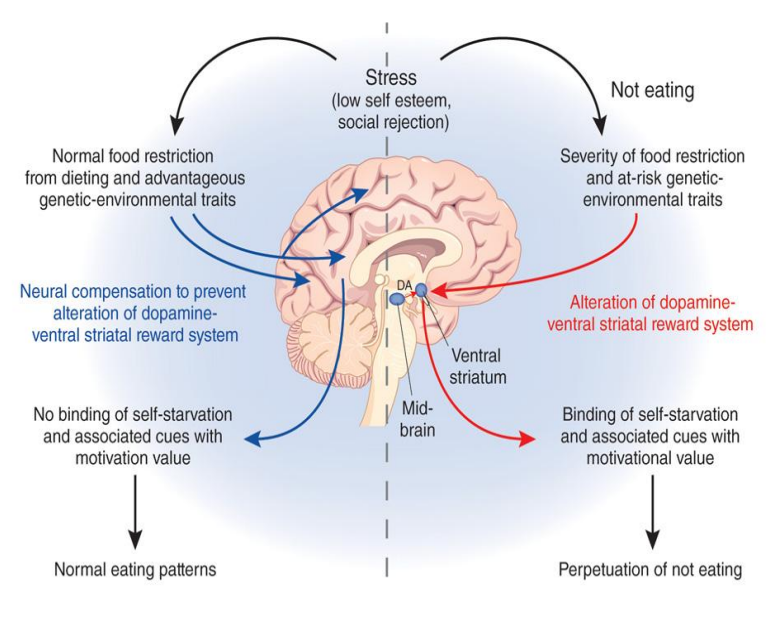
- Strict dieting
- Body dissatisfaction
- Perfectionism
- Family history of eating disorders
- History of physical or sexual abuse
- Low self esteem

CAUSES

- Socio cultural factors
- Biological factor
- Genetic factors



PATHOPHYSIOLOGY



WARNING SIGNS

- Refusal to eat & rapid weight
- Denial of hunger.
- Difficulty in concentration.
- Making excuses for not eating.
- Obsession with body size & shape

PRIMARY SYMPTOMS

- Resistance to maintaining body weight.
- Fear of weight gain or being’ fat’
- Disturbances in body weight & shape.
- Loss of menstruation.

DIAGNOSTIC EVALUATION

- Weight calculation by measuring Body Mass Index

Avoidance of fattening foods

Body image disturbances

Endocrine disorder

TREATMENT

- Participation & support of family members will provide success treatment .
- On earlier stage anorexia nervosa can be treated easily

- Effective communication strategies
- Cognitive behavior therapy
- Psychotherapies(individual, family, group)
- Antidepressants

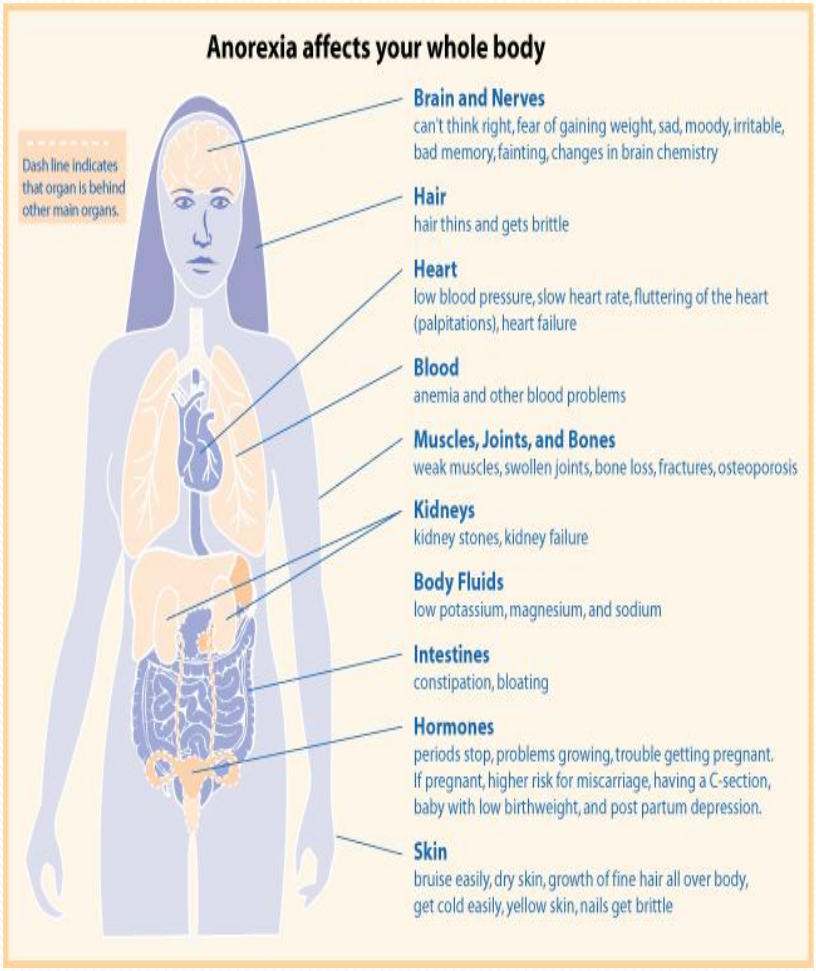
MANAGEMENT

- Efforts to change the maladaptive eating behaviors

Seeking medical attention for weight loss

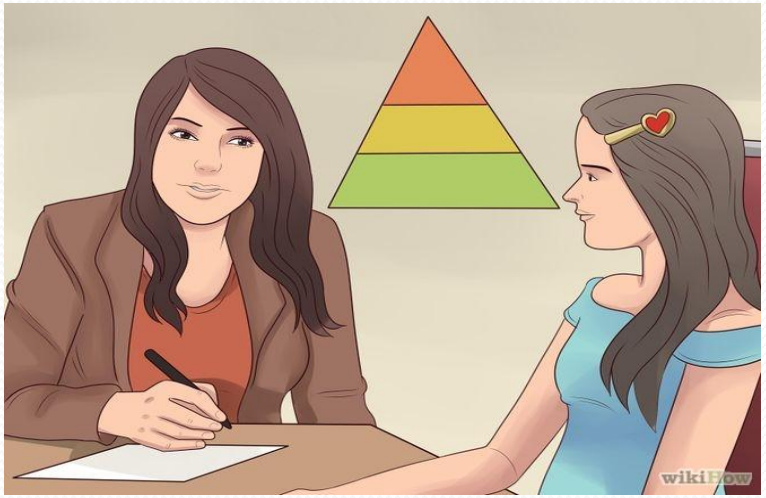
Willingness to accepting the concept of intake

COMPLICATIONS



PREVENTION

- **Aim;**
- To rule out the medical complications
- **Primary Prevention:**
- Identify risk groups and educate about nutrition,
- Provide counseling to the Adolescents, family, schools & college students.
- Effective communication



Secondary prevention;

- Reducing the duration of anorexia nervosa
- Nutrition education,
- Fitness comes in all sizes
- Say no to teasing
- Emotional bites
- Treatment

CERTIFICATE OF CONTENT VALIDITY

This is to certify that the tool for **"Effectiveness of structured teaching programme on knowledge regarding anorexia nervosa among the adolescent girls in selected college at Sivagangai".** Prepared by FLARENCE ANITHA.I , final year M.Sc. Nursing student (Mental Health Nursing), RASS ACADEMY COLLEGE OF NURSING ,POOVANTHI, is found to be valid and highly relevant.

Place : Mamaladurai

Date : 9.02.2015.

R. Rajaramani D.
Signature

MRS. ROJARAMANI.D,
ASST. PROF.
DEPT. OF. PSYCHIATRY,
Matha college of Nsg.
Mamaladurai.
SVG DIST.

APPENDIX-II

PERMISSION LETTER FOR CONDUCTION OF STUDY

TO

THE PRINCIPAL,
MADURAI SIVAKASI NADAR'S PIONEER
MEENAKSHI WOMEN'S COLLEGE,
POOVANTHI.

Respected sir/ madam

Sub: permission to do research – project m.sc nursing

I Mrs .I.Flarence Anitha ,II year M Sc Nursing student of Mental health nursing specialty at RASS Academy College of Nursing, which to do the project on the topic of **"Effectiveness of structured teaching programme on knowledge regarding anorexia nervosa among the adolescent girls in selected college at sivagangai district",** for my dissertation to be submitted to DR.M.G.R Medical university in partial fulfillment of the requirement of Degree of Master of Science in Nursing. So I request you to grant permission to undertake the study for adolescent girls in your esteemed institution in the month of February 2015. So please accept this permission letter and kindly do the needful.

Thanking you

Yours faithfully,

[MRS.I.FLARENCE ANITHA]

Place: Poovanthi

Date:

PRINCIPAL
RASS ACADEMY COLLEGE
OF NURSING
POOVANTHI - 630 611

permission Granted to conduct on 2/2/15

Principal
Madurai Sivakasi Nadar's Pioneer
Meenakshi Women's College
Poovanthi-630 611

APPENDIX - IX

LIST OF EXPERTS

Dr.Prof.S.Rajina Rani M.Sc(N),P.h.D,
Principal,
RASS Academy College of Nursing,
Poovanthi,
Sivagangai District.

Prof.Mrs .R. Ruth Rani, M.Sc (N),
HOD of Psychiatric department,
RASS Academy College of Nursing,
Poovanthi,
Sivagangai District.

Mrs.H.UmmulHapipa, M.Sc (N),
Vice Principal and HOD of Medical Surgical Nursing,
RASS Academy College of Nursing,
Poovanthi,
Sivagangai District.

Dr.V.Ramanujam, MBBS,M.D, (PSY)
Medical officer,
Srinivasa hospital,
Sivagangai.

Mrs.D.Rojaramani, M.sc(N),
Assistant professor,
Matha College of nursing,
Manamadurai.
Sivagangai Dist.

Prof.Mrs.V.JecinthaVedanayagi, M.sc (N),
HOD of Psychiatric Nursing,
Sacred Heart Nursing College,
Madurai.

Mrs.S.Induja, M.Sc (N),
Professor,
Sacred Heart Nursing College,
Madurai.

Mr.P.Selvaraj, MSc (N),
HOD of Psychiatric Nursing,
Shanmuga College of Nursing,
Salem.

Mr.Sam Ebenezer, MSc (N),
HOD of Psychiatric Nursing,
Shri Nithi College of Nursing,
PottaPalayam,
Sivagangai District.

DR.Varadharajan M.sc.,M.phil.,M.Ed.,Ph.D(Edn),
Professor of psychology,
RASS Academy College of nursing,
Sivagangai.

APPENDIX - X

Photographic evidence of data collection